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Leaflet Regarding Rules of Publication.—CALIFORNIA AND WESTERN MEDICINE has prepared a leaflet explaining its rules regarding publication. This leaflet gives suggestions on the preparation of manuscripts and of illustrations. It is suggested that contributors to this Journal write to its offices requesting a copy of this leaflet.

DEPARTMENT INDEX

(Itemized Index of Articles is printed on Front Cover)

EDITORIALS

CALIFORNIA PHYSICIANS' SERVICE AND FEDERAL HOUSING PROJECTS IN CALIFORNIA

Professional Members Have Been the Underwriters of California Physicians' Service.—More than five thousand members of the California Medical Association voluntarily joined California Physicians' Service as professional members, in order to promote the state-wide medical service that was brought into being by the California Medical Association. These professional members are the financial backers, or underwriters, of California Physicians' Service since, as professional members, they agree to render medical and surgical services on a nominal unit fee-schedule basis—which at the end of four years has not yet come up to 100 per cent of the initial unit values.

It is not necessary to discuss why such is the case, because the monthly reports and other comments which have appeared in CALIFORNIA AND WESTERN MEDICINE have given information thereon. It is to the credit of California Physicians' Service that some of its troubles have resulted from the well-meant effort to give the fullest amount of medical service.

* * *

California Physicians' Service Has Coöperated With the Government.—In line with its basic intention to be of service to California, California Physicians' Service has endeavored to cooperate with governmental agencies. Therefore, when thousands of workers gravitated to the war-industry centers such as the San Diego and the San Francisco Bay regions, it was natural for the governmental authorities to turn to California Physicians' Service and make request for a plan that would provide adequate medical care for the families of war workers.

The story of what subsequently transpired in some of the housing centers has been outlined in the OFFICIAL JOURNAL (August Calif. and West. Med., on pp. 142-144; September, pp. 193-195).

At its 312th meeting, held on August 22, the California Medical Association Council gave earnest consideration to the complications which had arisen (CALIFORNIA AND WESTERN MEDICINE, September, pp. 171-172), and which had made it necessary for California Physicians' Service to notify the Federal Public Housing Authority that on September 30, 1943, it would be obliged to terminate its contracts. The reason for the action was due to the fact that the professional members of Cali-

fornia Physicians' Service who had been rendering professional services in the housing projects—upon the basis of the nominal fee schedule adopted—had given medical care during the period September, 1942 to May, 1943, amounting to a total of $365,000, whereas the total received from the housing-center tenants amounted to only $241,000, approximating an average monthly loss to California Physicians' Service in excess of $12,000. Members who desire a clear understanding of the situation should read the items referred to.

Representatives of California Physicians' Service and the California Housing Authorities found it necessary to journey to Washington to place the problems before the federal officials in the effort to provide care for the housing tenants. As stated, the original contracts were abrogated on September 30, 1943. However, the medical service is being continued by California Physicians' Service under an emergency arrangement with the federal authorities, wherein lesser coverage is granted. Additional information concerning this is given in the California Physicians' Service department in this issue. It is to be hoped that satisfactory solutions of a permanent nature will be brought into being.

MATERNITY AND PEDIATRIC PLAN OF THE FEDERAL CHILDREN'S BUREAU

Payment Plan of Children's Bureau Objectionable.—Commencing in the June issue, editorial and other comment on the maternity-pediatric plan of the Children's Bureau of the United States Department of Labor has appeared in each issue of CALIFORNIA AND WESTERN MEDICINE. (References: June issue, on p. 314; July, pp. 1 and 79-88; August, pp. 105 and 133; September, pp. 156 and 178-182.)

The objectives contemplated in the federal appropriations to be made through grants-in-aid to state boards of health, for the purpose of providing adequate obstetric, pediatric, hospital and nursing care for the wives and infants of enlisted men in the armed forces, is one with which the medical profession everywhere has been and is in full accord.

Not so, however, as regards the methods of payment for medical services to be rendered to these patients, as designed and promulgated by the authorities of the Federal Children's Bureau in Washington, D. C. In some of the references given above, attention is called to deficiencies in the plan proposed by the Children's Bureau and to resolutions by national and state medical societies in which request is made that proposed fee schedules for professional services shall provide that the monies paid through a state board of health shall be made direct to the wife, and not to the attending physician; the patient to make her own financial arrangements with her attending physician.

* * *

The Menace of the Arbitrary Fee Schedule.—The Federal Children's Bureau, however, contends it can make no such arrangements. If the Bureau's decision stands, it means that an arbitrary fee schedule for obstetric-pediatric care, averaging somewhere between $35 and $50 will become operative from one end of the United States to the other, to apply to the wives of enlisted men. The significance of this rests on the fact that the armed services may include more than ten million enlisted men.

Now it is not possible to say when the present global war will end. In the meantime, the below-cost schedules of $35 to $50 to cover prenatal, confinement and postpartum care will become firmly established in the minds of hundreds of thousands of American citizens. Consequently, in the post-war period, fees in excess of the below-cost schedules of $35 and $50 will be looked upon by many citizens as extortion or something worse. Not a pleasant reaction for physicians to anticipate.

Under existing conditions, with the great demands now made upon the time and services of members of the medical profession, it is held by many physicians and others that the quality of obstetric-pediatric service under the plan inaugurated by the Federal Children's Bureau will not measure up to the best standards of the past. If such be the result, the supposed aid to the wives and infants of enlisted men will not be the generous gesture outlined in the basic objective. Further light is shed on this in articles to be found on pages 227–228.

* * *

Concerning Additional Payments by Patients.—In CALIFORNIA AND WESTERN MEDICINE for July, under Item VI on page 81, appeared the maternity-pediatric resolution adopted by the Council of the California Medical Association, and under Item XI on page 83, the letter sent to the component county medical societies. Attention is called to the second-last paragraph of the letter of July 1, 1943. A correction was made as given in the later Council proceedings (September CALIFORNIA AND WESTERN MEDICINE, on page 171). To prevent misunderstanding, the present procedure of the California State Board of Public Health appears below:

"Attention was called to the statement received from the California State Board of Health that, when a physician contracted to accept obstetric or pediatric work under the Federal Children's Bureau plan, the physician under the regulations put forth by the Children's Bureau of the United States Department of Labor is not permitted to accept the payment from the California State Board of Public Health—acting for the Federal Children's Bureau—and also accept an additional payment from the patient *for the same service*. However, for services to mother or child that are not included in the authorized schedules of the Children's Bureau, payments therefor may be made by the patient."

Additional information concerning the maternity-pediatric program and resolutions adopted by some of the component county medical societies in California appears in the current issue (Items XXIV–XXX, on pages 226–230).

Because the plan of the Federal Children's Bureau has such broad implications in relation to present and future medical practice, it will be of interest to note how its administration will work out in actual practice in the months ahead.

AN AUTHOR, de KRUIF, FINDS IN CALIFORNIA THE SOLUTION OF FUTURE MEDICAL PRACTICE!

Comments on a Book Review.—Last month CALIFORNIA AND WESTERN MEDICINE received for review a copy of the book, "Kaiser Wakes the Doctors," by Paul de Kruif. Comment is here made on the volume because the author, as a result of visits to the Kaiser shipyards in the San Francisco Bay region, has persuaded or entranced himself into proposing that the solution of the problem of providing adequate medical care for all classes of citizens is to be found in the medical service arrangements that have been set up in the shipyards located in Richmond, California, at Vancouver, Washington, and other places where Mr. Henry Kaiser and associates have installed their wartime industries.

In the description of the plans he discusses, de Kruif makes more than generous use of superlative adjectives, the three personages who receive most of his superpraises being: the director of the shipyards, Mr. Kaiser; its medical supervisor, Doctor Garfield; and the author himself, Mr. Paul de Kruif.

If the plan of medical service as it is being operated in the enterprises of the Kaiser interests possessed all the merits so enthusiastically portrayed by de Kruif, and if the procedures propagandized by him were new and particularly could be used in urban and rural districts of California and other states where altogether different conditions exist, then the laudations so generously bestowed upon Messrs. Kaiser, Garfield, and de Kruif might not only be justified but perhaps might even be accepted by the medical profession, which is the one group of citizens whose members have the most direct and intimate knowledge of the medical care problems which the book attempts to discuss.

* * *

Excerpts in This Issue.—In this number,* excerpts from de Kruif's opus, with comments thereon, are presented for the convenience of readers who may be reluctant to pay two dollars for the opportunity to read his cure-all exposition or advocacy of the millenium in medical service—at least until they have first assured themselves that the expenditure involved will be justified. Members of the State Association should take the time to scan the items referred to, since the story largely revolves around plans now in operation in California. After perusal of the excerpts and comments, readers may more easily decide whether they wish to embark upon the financial outlay involved in purchase of the author's effort as given in some 158 pages of text.

* See article, "Kaiser Wakes the Doctors?," on page 244.

Author's Analogy Is Faulty.—In the volume, de Kruif as analogist†, outlines the plans of the Permanente Foundation and related medical services now offered in the shipyards, where 50 cents per week is deducted from wages of each employee (there being practically no acquisition costs in securing members to the plan, certainly a great administrative saving!); the wage deductions being taken from a group of about 100,000 workers (the families, however, are not included!); the plan being in operation in enterprises where all the workers reside within a small and limited geographical area. In essence, the discovery—for that is how de Kruif seems to regard it—is nothing more than an application of the age-old principle of prepayments on an insurance basis, designed to give protective coverage to a limited group of poor risks through acquisition of a large number of paying good risks.

However, when from this special instance—of an unusual and wartime condition related to a large number of workers under a single management—de Kruif proceeds to draw the general conclusion, that the same degree of medical service could be brought into being throughout almost the entire United States, not only for workers but also for their families, and in regions where the wage-earners are scattered and working for many instead of a single employer, and so forth, one is tempted to wonder in what college or school of experience de Kruif took his courses in logic. When analogies used as premises are not sound, it follows that the conclusions and recommendations made thereon are in error. Many inconsistencies in statements and reasoning are presented by de Kruif, but for these, readers are referred to the book itself; or to the excerpts in this issue, which appear on page 244.

* * *

Regrettable Results of Promulgations Such as Those of de Kruif.—In spite of its radical proposals, it is not surprising that de Kruif's book has received some complimentary review notices from lay editors, whose lack of knowledge of medical practice prevents them from discerning the fallacies to be found in the author's expositions. For example, see "Books on Parade" review, on page 249.

Unfortunately, such reviews in the public press are read by a host of citizens, many of whom are thus led into accepting erroneous concepts concerning existing medical practice.

* * *

Interesting Statements by Mr. Kaiser.—Mr. Henry Kaiser himself seems to have fallen under the spell of either de Kruif's or his own thinking, if one may judge from recent press dispatches of a speech by him, which can best speak for itself. Quotation follows:

SEVEN CENTS A DAY MEDICINE SEEN

New York, Sept. 18 (INS).—Henry J. Kaiser foresees a future in which the health of the entire American popu-

† Oxford English Dictionary, in its definition of analogy, states "Presumptive reasoning based on the assumption that if things have similar attributes they will have other similar attributes." "Analogist, one who seeks, or argues from, analogies."

lation will be safeguarded by "little Mayo clinics"—small, personalized groups in which medical and hospital care is financed through individual payment of seven cents a day, or less.

The "miracle man of shipbuilding" told the convention of disabled American Veterans about it Saturday, and later amplified his statements in an interview with reporters.

Kaiser described his seven-cents-a-day system now in operation throughout his vast network of shipyard enterprises—a plan which he originated at Grand Coulee dam four or five years ago.

Plan Boosts Efficiency

"This is prepaid health insurance," he said, "and I believe it has increased our efficiency at least 5 per cent. In one month fifty-five doctors treated 125,000 patients. We don't just wait till they send for a doctor, who tells them they're sick enough to go to a hospital. We go out and send them to the hospital.

"I believe the future will see groups of 'little Mayo clinics' in hotels, in industrial plants, among merchants, and even in rural communities. It will be a great thing for the disabled doctors who come back from the war, too. There are now 100,000 doctors in our armed forces. Many will return disabled. Many will be able to carry on their profession in these clinics, despite the handicap."—Portland *Oregonian,* September 19.

In the above press item, the general and erroneous argument of de Kruif is again expounded, but through press association dispatches, owing to the present prominence of Mr. Kaiser, it has no doubt come to the attention of thousands and thousands of citizens. It is only another example that goes to explain why so many citizens throughout the nation have been misled into forming faulty opinions concerning modern-day medicine and practice, and emphasizes again why the medical profession should carry on consistent educational campaigns in which actual facts and truths concerning medical service and practice will be presented to the public.

Readers of CALIFORNIA AND WESTERN MEDICINE may find it worth while to refer to the review excerpts from de Kruif's book, printed elsewhere in this issue. Comment is there made for which no place can be found in this department of the OFFICIAL JOURNAL

WAGNER-MURRAY BILL: CRITICISM FROM AN UNSUSPECTED SOURCE

Health and Sickness Legislation in California.—The first major attempt to inflict a compulsory health insurance plan upon California was made more than twenty-five years ago. Mr. Chester Rowell of San Francisco, well-known editor and publicist, was the chairman of the State Commission in charge of the effort, and Miss Barbara Nachtrieb its secretary. A quarter of a century later they were still active in their propaganda. So much so, that Governor Olson appointed them to the same positions when, several years ago, he attempted, unsuccessfully, to drive a "must pass" compulsory health insurance measure through the California Legislature.

* * *

Columnist Rowell's Criticisms of the Wagner-Murray Bill.—Mr. Rowell, in his syndicated press column, again and again has discussed health or sickness insurance. In his comments he has not been backward in casting blame upon organized medicine and its representatives as being responsible in good part for the non-enactment of proposed statutes designed to bring sickness insurance into operation under State control.

When on September 7, 1943, he printed some sharp criticisms of the Wagner-Murray-Dingell Bill (S. 1161), his action took on interest for Californians. In this place, only brief excerpts are given, the complete article appearing in the Department of the Committee on Public Policy and Legislation, on page 233.

Somebody sends a reprint of a letter from a Chicago correspondent to the *Christian Science Monitor* quoting medical, not Christian Science, objections to an alleged "Wagner-Murray" bill said to be before Congress which, under the guise of sickness insurance, has for its real purpose the destruction of "free economy" and the "complete bureaucratic domination of the American people," and the reduction of the doctors to "abject slavery." . . .

But all this has nothing to do with the immediate publicity, which is all quoted from one John M. Pratt, "executive administrator" (in other words, publicity agent) of the "National Physicians' Committee." . . .

We have not seen the text of this alleged sickness insurance bill, but if it even remotely resembles the account of it quoted from Mr. Pratt, it could scarcely receive a single vote in Congress and would certainly be repudiated by every informed supporter of health insurance. There were no such provisions in a single health insurance system in the world in the days before the war when every civilized country except the United States had such a system, and this writer at least, who has for fifty years been urging the adoption of health insurance by American states, never heard of any such proposal here—except in the bugaboo publicity of paid lobbyists. . . .

Here, however, is one of them who, like the gentleman from Missouri, waits to be "shown."

In the above, Mr. Rowell states he was not in possession of a copy of the Wagner-Murray Bill, but he has no doubt made request therefor. After he peruses the text of S. 1161, he will probably find that the statements concerning its contents and scope, as put out by the National Physicians' Committee, are quite to the point. In view of his implied condemnation of the measure—on the basis of the N. P. S. digest—it will be interesting to observe what trend future remarks by Mr. Rowell on the Wagner-Murray-Dingell Bill (S. 1161) will take.

IN RETROSPECT: ON TWO MILITARY ITEMS

Physicians Enrolled in Armed Services in World War I.—Some readers have established the habit of scanning the items which appear in the Twenty-Five Years Ago department, to be found always on the last text page of every issue of CALIFORNIA AND WESTERN MEDICINE. Because many other members may not read that column, two excerpts in the current issue appear below, which should be of interest since they shed light on the activities of the medical profession in World War I. Colleagues of twenty-five years ago set an excellent standard.

Quotations follow:

Fifty Thousand Medical Officers.—With an army of three million men in the field [October, 1918] or in training and as contemplated, an expansion of this force to five million men, the Surgeon General must have in the Medical Reserve Corps at least fifty thousand doctors. The Medical Reserve Corps must keep pace in growth with the army expansion and it behooves every doctor in the United States between the ages of 21 and 55, who is physically, morally, and professionally fit, at the earliest possible moment to arrange his personal affairs so as to offer his services to his country in the capacity of a medical officer. The United States is in the war to win and this can only be accomplished by a large and well-trained body of troops adequately cared for by a sufficient number of medical officers. The importance of the doctor's service and its relation to the successful outcome of the war cannot be overestimated. . . .

* * *

Volunteer Medical Service Corps.—To date [October, 1918] about 40,000 of the 144,116 doctors in the United States—not including the more than 5,000 women doctors—either are in Government service or have volunteered their services. Up to July 12 the Surgeon-General had recommended to the Adjutant-General 26,733 doctors for commission in the Medical Reserve Corps. About 9,000 others who applied were rejected. With the 1,194 in the Medical Corps of the National Guard and 1,600 in the Navy, the total—38,527—constitutes 26.73 per cent of the civilian doctors. Deducting those who declined their commissions or who have been discharged because of subsequent physical disability or other cause, the number actually commissioned in the Medical Reserve Corps stands (August 23) at 23,531 with several hundred recommended whose commissions are pending. Of the 23,531, there are 22,232 now on active duty. . . .

EDITORIAL COMMENT†

AUTOALLERGIC DERMATITIS

In 1934, Whitfield[1] introduced the term "autosensitization eczema" to explain certain puzzling dermatoses, which he believed were due to the patient's acquired sensitization to the slightly denatured organ-specific proteins of his own skin. This nomenclature offered a convenient explanation for the apparently spontaneous continuation or spread of eczematous and urticarial lesions, for the jumping about, waxing and waning of such lesions, and for their appearance at the site of minor skin irritation. The nomenclature, however, was received with skepticism by most professional immunologists since it was not based on experimental evidence that dermal proteins are organ-specific and can function as isoantigens. Proof of dermal isoantigenicity, however, is currently reported by Hecht[2] and his associates of the United States Army Medical Corps, and the Department of Dermatology, University of Illinois.

Finely minced rabbit skin was mixed with an equal volume of aluminum cream, according to the Walker[3] technique and the mixture injected into the muscles of the hindlegs of normal rabbits to form several deposits of skin material which presumably would be slowly autolysed and absorbed. Heart blood drawn at weekly intervals from the injected rabbits was titrated for antiskin precipitin; filtered rabbit skin autolysate being used as test antigen. This autolysate was prepared by 150-hour incubation of finely minced rabbit skin suspended in an equal volume of saline solution. Four rabbits thus tested showed no suggestion of specific antiskin precipitins (ring test). In two other rabbits, however, the faintest suggestion of a positive reaction was noted.

These findings are reminiscent of earlier results with homologous lens proteins, most investigators reporting only an occasional faintly positive isoantigenic reaction. It was subsequently shown,[4] however, that autogenous lens proteins could be "potentiated" or otherwise increased to full antigenicity by mixing them with staphylococcus toxin or by a simultaneous injection of lens protein and toxin. Applying this technique, Hecht injected other groups of rabbits intramuscularly with rabbit skin material, followed by repeated daily intracutaneous injections of staphylococcus filtrate. All rabbits thus injected developed relatively high titer specific antiskin precipitins. In some cases the titer reached three plus or even four plus on their precipitin scale. Rabbits injected with staphylococcus toxin alone and all untreated controls gave uniformly negative results.

Hecht found that rabbits which had thus developed antiskin precipitins manifested "special kinds of lesions" (details not given) when their skins were subjected to various kinds of trauma and irritation. Rabbits without demonstrable antiskin precipitins failed to develop these types of lesions in response to identical forms of skin trauma. The work of the Illinois dermatologists, therefore, offers belated scientific evidence for the "autosensitization eczema" or autoanaphylactic dermatitis of current clinical nomenclature.

P. O. Box 51.

W. H. MANWARING,
Stanford University.

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† This department of CALIFORNIA AND WESTERN MEDICINE presents editorial comments by contributing members on items of medical progress, science and practice, and on topics from recent medical books or journals. An invitation is extended to all members of the California Medical Association to submit brief editorial discussions suitable for publication in this department. No presentation should be over five hundred words in length.

Now more than at any other time, because of the pressure of work, longer hours, and crowded and unsatisfactory living conditions, there is reason for extra precaution so far as tuberculous infection is concerned, both in large and small industries. Many individuals will have to be employed whose health is substandard and who should be considered more susceptible to such infection. Therefore, there should be more effort made to extend and maintain proper health supervision, especially in regard to the detection and control of tuberculosis.—W. A. Sawyer, M. D., *New York State Journal of Medicine*, January 15, 1943.

ORIGINAL ARTICLES

Scientific and General

LYMPHOCYTIC HYPERPLASIA AND "SPONTANEOUS" ALIMENTARY LESIONS*

A. W. Meyer, M. D.
Palo Alto

IN connection with his description of lymphocytic nodules,† Gerlach, 1854, represented "a solitary gland" of Peyer from the colon devoid of villi and covered by very low epithelium, as shown here in Figure 1.

While studying the lingual tonsil in 1882, Stöhr found the squamous epithelium "rarefied" wherever lymphatic nodules were numerous, and observed that the surface of the epithelium was covered by large masses of clumped "lymphoid cells." He said he had thought at first that these phenomena were pathological, but convinced himself to the contrary by examining similar material from freshly decapitated animals in all of which "lymphoid cells" lay singly and in masses between the epithelial cells.

In 1884 Stöhr observed what he called a massive penetration (massenhafte Durchwanderung) of the squamous epithelium over lingual and faucial tonsils, constantly present, and far from pathological. He further emphasized that although the "leukocytes"‡ passed between the epithelial cells they undoubtedly not only affected the function of the latter by their mass migration, but also destroyed them. He accompanied his discussion by fine drawings, one of which (Figure 14, Plate X) is reproduced here as Figure 2. Stöhr especially considered the gaps thus formed in the epithelium and suggested that microörganisms could, no doubt, get in as well as "leukocytes" could get out.

In 1889, he also observed "leukocytes" between and within the epithelial cells over intestinal lymph nodules and hence felt compelled to admit an invasion of the epithelial cells by "leukocytes." Although Stöhr did not recognize it, his description of these epithelial cells suggests that this invasion was taking place only into degenerate cells.

When studying the human appendix, Rüdinger, 1891, said that the epithelium was invaded by lymphocytes, especially where a "ripe" lymphatic nodule approached its undersurface. He thought that this invasion is periodic and concluded that the resultant changes in the epithelium led to the formation of new lymphocytes. He also reported that whenever a lymphatic nodule became large, it extended beyond the boundary of the muscularis mucosae and between Lieberkühn's glands (intestinal crypts) which were pushed aside and hence took a slanting position to the follicle. He was surprised by the absence of glands over the nodules, observed degenerative changes in glands which had become surroundel by lymphocytes and emphasized that they do not disappear merely because they are pushed aside, but, like Davidoff, 1887, concluded that "leukocytes" arise from dying epithelial cells.

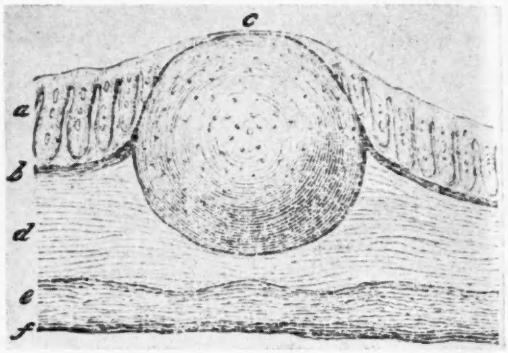

Fig. 1.—A solitary lymph nodule from the human colon after Gerlach, 1854; figure 156, showing the presence of low epithelium over the nodule. *a.* Lieberkühn's glands; *b.* muscularis mucosae; *c.* solitary lymph nodule; *d.* submucosa; *e.* muscularis; *f.* serosa X35.

It is especially noteworthy that when studying the development of the lymphatic nodules of the intestine, and the degeneration of the glands, Stöhr, 1898, found low epithelium over an appendicular nodule from a six-month-old fetus, and represented a dilated capillary very close to the undersurface of the epithelium, as represented in Figure 3.

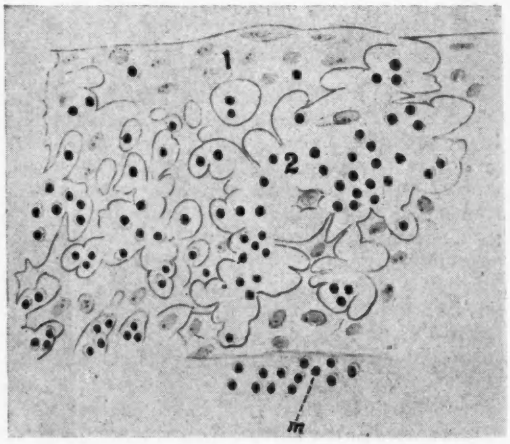

Fig. 2.—An exactly vertical section through the epithelium of a "follicular gland" from the tongue of a healthy adult male. Circa X400. The left half containing smaller and the right larger gaps in the mucosa. After Stöhr, 1884. 1. squamous surface epithelium. 2. spaces in the same made by the "leukocytes"; *m.* "leukocytes."

Von Ebner, 1899, also mentioned the absence of "glands" (crypts) over aggregate nodules and

* From the Department of Anatomy, Stanford University.

† The name Balgdrüse—follicular gland—was given lymphatic nodules of the tongue through a misconception and unfortunately was retained in the B. N. A. in the form of lymph follicle. They are, to be sure, not follicles (bags), but nodules, and not lymphoid (lymph-like), or composed of lymph, but of lymphocytes.

‡ Stöhr chose the word leukocytes in preference to lymphoid cells used in his earlier publication, because he regarded it as more noncommittal.

represented the epithelium without goblet cells and lower over them, in a drawing of a section taken from an appendix from a 23-year-old, beheaded individual, as represented here in Figure 4. He also represented a lymphatic nodule from the colon as having penetrated the muscularis mucosae and displaced Lieberkühn's glands, as represented in Figure 5. He found the squamous epithelium over the lymph nodules of the tongue displaced completely by leukocytes in some areas, as represented in Figure 6. A similar figure is found in the second, if not also in the first edition of the textbook of histology by Böhm and Davidoff, 1901,* and in the atlas of Sobotta, 1902 (Figure 2, Table 31). The latter found the epithelium lining a faucial, tonsillar crypt from an executed person 22 years old, in the condition represented here in Figure 7. In the legend, Sobotta stated that the basal limit of the epithelium cannot be recognized on the right, in the section, and in the second edition of this work, 1911, he again spoke of a mass passage (massenhafte Durchwanderung) of leukocytes through the epithelium. Since the Germans use the word "Einwanderung" for infiltration, it is clear that Sobotta, as Stöhr, 1884, who first used the term "Durchwanderung" in this connection, thought that great masses of leukocytes actually passed to the exterior through the epithelium, not merely into it.

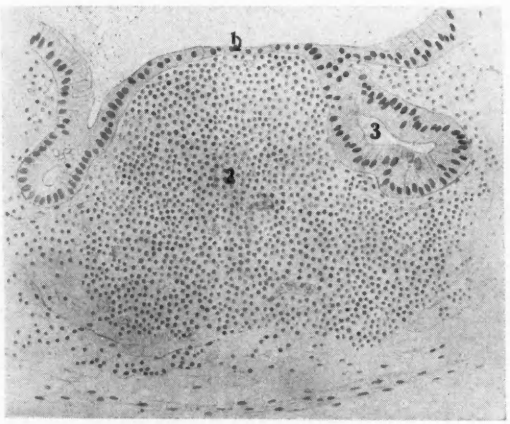

Fig. 3.—A section through an appendicular lymph nodule from a six months' fetus after Stöhr, 1898; figure 23, also showing a lower epithelium over the developing follicle. 1. epithelium; 2. lymph nodule; 3. glands of Lieberkühn; muscularis mucosae below.

AUTHOR'S OBSERVATIONS

While searching for an explanation for the very common presence of individual and multiple cysts in the pharyngeal and their practical absence in the faucial tonsils, in dissecting-room bodies, I could not help but be impressed by the striking transitions in the squamous epithelium over the surface of faucial and pharyngeal tonsils, and in their crypts, as represented in Figure 8, after Braus, 1924 (Figure 69). It will be noted that a rather sudden transition from the usual thick squamous epithelium to a mere line containing an occasional small, degenerate nucleus, is shown on the upper right, opposite, or over, a hyperplastic lymphatic nodule. Such transitions in the epithelium were common upon the surfaces as well as in the crypts of young, decidedly hyperplastic, healthy, faucial and pharyngeal tonsils removed operatively in 1928, and fixed immediately in Bouin. It is interesting, startling, in fact, that Braus regarded the resultant lymphocytic squamous epithelial mass as a "mixed lympho-epithelial organ" in which the two cell types were in symbiosis!

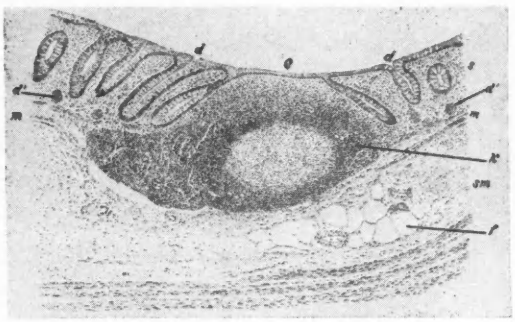

Fig. 4.—A portion of a transverse section through an appendicular lymph nodule from a 23-year-old guillotined man after von Ebner, 1899, figure 998, showing displacement of the adjacent crypts, absence of a propria, etc., and lower epithelium over the nodule. *d.* glands with goblet cells; d^1. sections of the ends of glands; *e.* epithelium over the solitary nodule without goblet cells. *s.* mucosa. *m.* muscularis mucosae interrupted by the nodule; *sm.* submucosa with vessels and fat cells.

Böhm and Davidoff, 1901, on the other hand, said (page 225) that "The epithelial walls of the follicular cavities often show extensive degenerative changes, which are accompanied by increased migration of leukocytes into the oral cavity," and added on the next page, "The epithelium lining the crypts or cavities of the tonsils shows, as in the lingual follicles, extensive degenerative changes, resulting mainly in the formation of variously shaped (sic), communicating spaces filled with

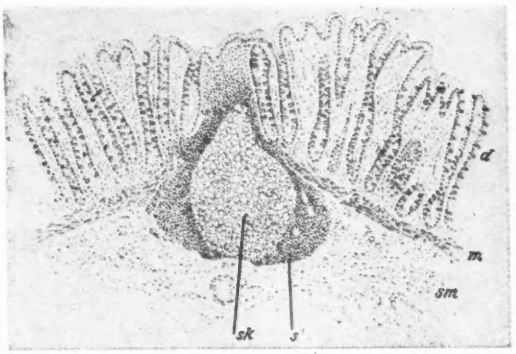

Fig. 5.—A transverse section of the colonic mucosa after von Ebner, 1899, figure 999, showing the absence of goblet cells in the epithelium over the nodule, penetration of the muscularis mucosae and extension of the lymphatic tissue to the under surface of the epithelium X35. *d.* Lieberkühn's gland, goblet cells dark; *m.* muscularis mucosae; *s.* solitary nodule; *sk.* secondary nodule; *sm.* submucosa.

* The first edition, in German, appeared in 1895; the second in 1898.

lymphocytes and leukocytes." Stöhr, 1884, on the other hand, thought that the infiltrated lymphocytes multiplied by mitosis, and were increased in number by further infiltration to form the spaces in the epithelium he saw and represented as shown here in Figure 2.

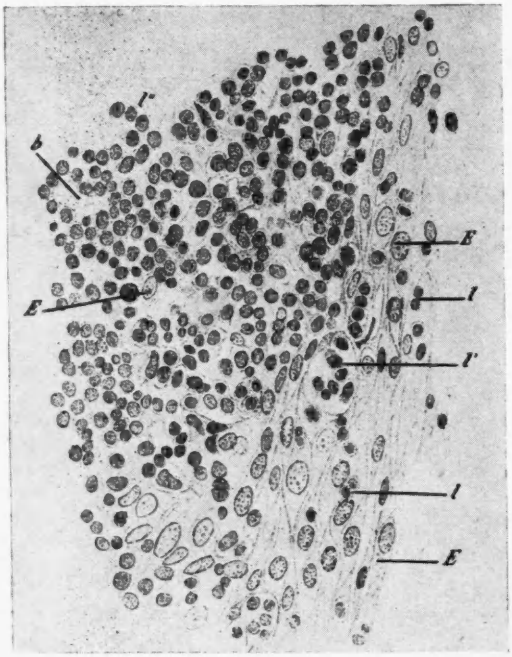

Fig. 6.—A portion of a vertical section of the epithelium from the "root" of the tongue after von Ebner, 1899, figure 898 (X500) said to show "passage" of lymphocytes through the epithelium. E=epithelium; 1, 1' and 1"="leukocytes" which in the case of 1" have completely pushed aside (verdrängt) the epithelium; *b*. blood vessel.

Upon further study of lymphocytic nodules of the oral cavity and the alimentary tract, I found that similar infiltration and destruction of the epithelium occurred wherever hyperplastic lymph nodules, whether isolated or aggregate, were present and that this phenomenon was especially common and probably universal in appendices not known to be or regarded as diseased. This condition, destruction of epithelium, is illustrated well by specimens in histological teaching collections and is represented in a fine drawing by Ruth Huntington, published by Kelly, 1905, of a section from an allegedly "normal appendix," a portion of which is reproduced here as Figure 9. That similar conditions are common in appendices is indicated by the studies of Aschoff, 1912 and 1930, and especially by that of Shelly, 1937, of 155 and 2,065 appendices, respectively, removed incidentally.

The absence of villi, crypts and goblet cells especially over aggregate lymph nodules has long been known, and that the last two also may disappear over hyperplastic lymphatic nodules in the appendix also was noted. Unless the crypts remained intact and gradually shortened until they disappeared, it follows that their destruction accompanying

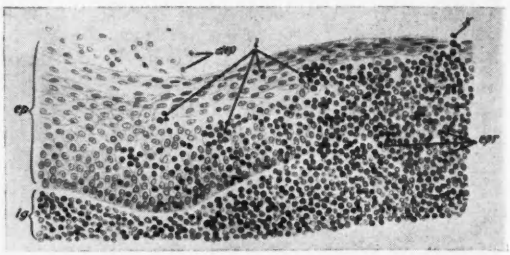

Fig. 7.—A section through a part of the mucosa of a tonsillar sulcus (Bucht) (crypt) after Sobotta, 1902, figure 2, plate 31, said to illustrate the penetration (Durchwanderung) of the epithelium by "leukocytes" until only nests of epithelial cells are left at the right where the basal limits of the epithelium are said to be unrecognizable. (X220.) d. ep., desquamated epithelium in a tonsillar sulcus; ep., epithelium; ep. r, epithelial remnants; l, leukocytes; lg, lympoid tissue of the mucosa; X, leukocytes advancing into lumen of a tonsillar crypt.

lymphatic hyperplasia must be accompanied by the production of a break, or breaks, in continuity somewhere along their tubular bodies. Moreover, marked lymphatic hyperplasia cannot occur without derangement of the architecture of the mucosa and interference with the function of the structures affected.

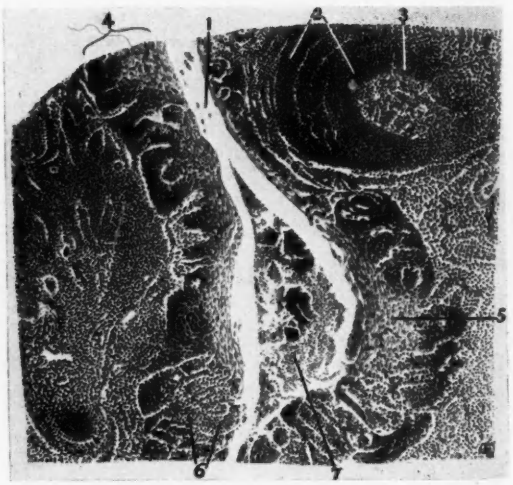

Fig. 8.—Migration of lymphocytes into epithelium of a crypt. (X68.) After Braus, 1924. Note especially the region of the nodule where the epithelium is reduced to a very thin layer containing a few degenerate nuclei. 1. individual desquamated epithelial cells; 2. cortex of the lymph follicle. 3. germ center; 4. epithelium; 5. epithelium containing few lymphocytes; 6. intense infiltration with lymphocytes; 7. desquamated "epithelia" and emigrated lymphocytes in the interior of the tonsillar sulcus (crypt).

Bauer, 1921 (page 448), called attention to the relation between anatomical and functional disturbances in the intestinal absorption areas associated with "inordinate loading" with albumen alone, which resulted in the entrance of foreign protein. How much greater, then, may such absorption become when epithelium—squamous or columnar—is decidedly atrophic or destroyed altogether! Moreover, upon the exposure of the hyperplastic lymphatic tissue to the lumen, external agents of all kinds can freely enter or attack it. Because of the

great number of lymphatic nodules in the alimentary canal, an endless number of places of lowered resistance of all degrees hence can be formed through, or during, lymphatic hyperplasia alone. It is not necessary, to be sure, that more than one nodule becomes hyperplastic to intensify the allergic response or permit infection. The occurrence of local responses of lymphatic tissue are well established and that places of damage to the epithelium commonly are present in the alimentary tracts from individuals devoid of clinical signs or symptoms of disease, has been abundantly established through microscopic examination. However, it is not implied, to be sure, that loci of lower resistance are not produced in any other way or that their production must always be accompanied by lymphatic hyperplasia, infection or clinical symptoms or signs of illness.

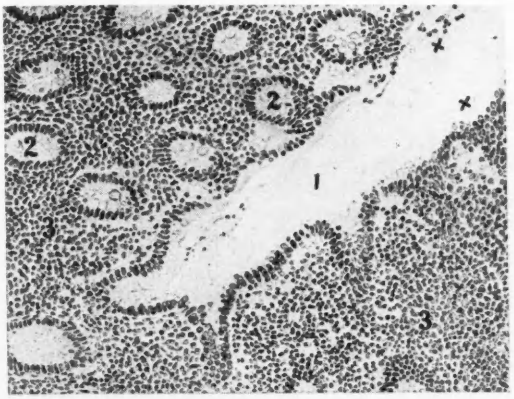

Fig. 9.—"Portion of the normal mucous membrane of appendix X150" from Kelly, 1905.—Note the absence of epithelium at X along the upper portions of the appendicular sulcus. Only the pertinent portion of the original is reproduced here. 1. sulcus in the appendicular mucosa; 2. crypts in section; 3. lymphocytes.

The atrophy and destruction of squamous and columnar epithelium of the alimentary tract emphasized here, and the related phenomena, it seems to me, offer a satisfactory answer to Aschoff's question, 1912 (page 99), as to "why the harmless residents of the appendix suddenly cause an acute attack" and confirm his conclusion, reached after a generation of study, that "The condition for the occurrence of appendicitis must reside in the normal appendix and its pathogenesis can only be studied with success on such pure cases." They further explain why "Appendicitis arises purely locally as a rule in the distal portion of the appendix" and why (page 16) "Every case of appendicitis develops on the basis of a local enterogenous infection in a specifically disposed appendix." Although not every case arises in this way, this does not invalidate my conclusion.

My observations do not confirm his belief that the cause of appendicitis "must and will be found in mechanical conditions" such as a slight flexure of the distal portion of the appendix, stressed by Aschoff. However, in so far as such very slight and severer flexures are due to asymmetrical lymphatic hyperplasia, so common not only in the appendix, or to consequent local obstruction of its lumen, mechanical conditions may, to be sure, be involved.

Furthermore, Aschoff (page 5) probably was correct in saying that "in the majority of cases, in which especially marked development of the lymph nodules, a very marked increase of the lymphatic elements . . . is present, we must think of a local or general status lymphaticus." It is of special interest that Shiota, 1909, concluded that there was a direct relationship between lymphatism and the length of the appendix and that Bauer, 1921, felt that a constitutional factor was concerned in appendicitis.

Aschoff, 1911 (page 759), claimed that in cases of acute appendicitis, six hours after the onset of symptoms of abdominal and localized pain on pressure and low fever, the "primary infect"* can always be found upon microscopical examination of the appendix, even when it looks entirely normal except for slight injection of the serosa. He emphasized that a sufficiently careful microscopic search always reveals a slight epithelial defect in one of the sulci in the mucosa, which contains a plug composed of leukocytes and fibrin from which a marked, wedge-shaped mass of "leukocytes" penetrates all layers of the appendicular wall, even when the serosa showed only slight evidences of beginning exudation. It is difficult to believe that the defect which Aschoff called the "Primarinfekt" actually was not a locus minoris resistentiae in the epithelium produced by lymphatic hyperplasia instead of such a manifest artifact as he represented, or that the cases of fleeting or fugitive appendicitis, of which he and others have spoken, are not occasioned by periodic hyperplasia in lymphatic nodules with the production of primary defects in the mucosa sufficient to produce disease.

DISCUSSION

The best-known characteristics of lymphatic tissue are its extraordinary variability in number, size and state, and its great lability. Passow, 1885, emphasized this in regard to the number of the intestinal nodules in different individuals, and Hofmeister, 1887, observed regressive changes in "adenoid tissue" in starvation. Stöhr, 1889, concluded that three days of starvation had greatly reduced the size of the nodules, and the withholding of food in cases of acute appendicitis, gastric and duodenal ulcers has become well established in practice. Aschoff referred to the reported infrequency of appendicitis during starvation in Russia, and the effect of diet upon lymphatic tissue was shown more recently by Settles (1920), Lefholz (1923), and Jackson (1925).

The reaction of the lymphatic nodes to physiological states such as exercise, pregnancy, etc., also

* The drawing (Fig. 19, Pl. IV, Aschoff, 1908) of a "Primarinfekt" is highly impeachable evidence, however. Such "Infekte" are present in large numbers in routine material. What is greatly needed is complete series of sections of entire appendices from persons of different ages not known to have suffered from appendicitis.

is well established and they may be allergic to various inhaled as well as ingested substances. Such allergic reactions could explain recurrent light or severe attacks not only of tonsillitis and appendicitis, but of ulcer—especially of esophageal, gastric, or duodenal ulcers. The occurrence of such loci of lowered resistance, and even of open portals in the mucosa, also can account for the common presence of relatively large masses of lymphocytes in apparently normal appendices, and over tonsils, which merely are hyperplastic. Were these masses to be regarded as having been formed through individual migration through a normal mucosa that migration would have to be far more active and the lymphocytes far more resistant than known to be after their entrance into the alimentary tract.

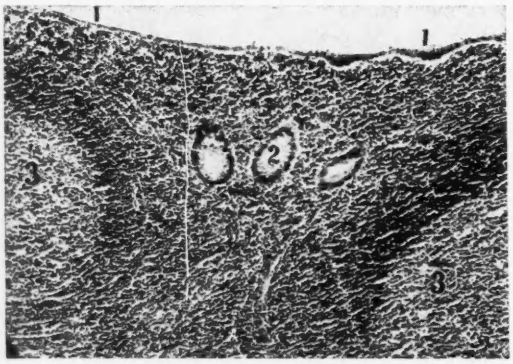

Fig. 10.—A photograph of a small portion of a transverse section of an appendix from a 32-year-old man (X75) showing the effect of lymphatic hyperplasia upon the epithelium and mucosa. 1. greatly reduced epithelium; 2. sections of a few remaining crypts; 3. lymph nodules. All the rest of the field is occupied by lymphocytes; no propria remaining. From the collection of Professor Alvin J. Cox.

The destruction of the appendicular epithelium and mucosa,* in consequence of noninfectious processes, offers a satisfactory explanation for the normal, nonpathogenic obliteration of the appendix, and can explain why that obliteration usually begins distally and why local constrictions and obliteration often occur. The lymphatic hyperplasia also offers an explanation for the so-called "erected" appendices which seem normal, and for temporary or periodic occlusions of the lumen or light passing attacks of appendicitis and for so-called "spontaneous" ulcer here and elsewhere in the alimentary tract.

That the atrophy and destruction of the tonsillar, appendicular, etc., epithelium—and mucosa—is effected from below and not from the surface, is splendidly illustrated by such specimens as represented in Figure 10. In this cross-section of an appendix from a 32-year-old male, only remnants of crypts, muscularis mucosae and epithelium remain over its entire interior. Wherever hyperplastic nodules approached near to the lumen, only an extremely thin remnant of the epithelium is left and contains some small gaps through which lymphocytes and blood have entered the lumen which contains some fecal contents. Aschoff, 1908, emphasized that he always found the appendicular mucosa intact over concretions, and the evidence that the alimentary mucosa suffers change from below in loci of lymphatic hyperplasia is conclusive. The main factors in this process seem to be interference with nutrition and lysis, not phagocytosis or disease as commonly understood. That even slight bleeding where defects exist may also facilitate infection needs no comment.

I realize, to be sure, that the constant association of phenomena does not in itself relate them as cause and effect. However, since the existence of loci of lowered resistance of all degrees from the disappearance of brush borders and goblet cells to complete destruction of the mucosa is undeniable, the manner of their production cannot affect the conclusions drawn regarding the possibility of infection through, or digestion of, damaged epithelium and destruction or sloughing of the nodules. Moreover, not only the epithelium but the entire mucosa and even portions of the submucosa may be and often are affected by the hyperplasia, including smooth muscle, etc., in the villi as well as in the muscularis mucosae. In cases of marked diffuse hyperplasia, all these structures may be involved similarly.

That the control of lymphatic hyperplasia may point the way to relief from various lesions of the alimentary tract would seem self-evident and should need no emphasis. I shall, therefore, refrain from citing manifold evidence from clinical literature in support of the conclusion presented here upon the basis of evidence revealed by others and upon personal and departmental observations and other material kindly put at my disposal by my colleague, Professor Cox.

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* In the older literature, the word mucosa is sometimes used in a restricted sense. It, of course, includes epithelium, propria and muscularis mucosae, with the contained vessels, nerves and lymphatic tissue.

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(References continued on page 240)

NEW TRANSVERSE LOW ABDOMINAL INCISION*

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THE incision to be described, when compared with the vertical incisions, presents several advantages: a better exposure with lighter anesthesia, a more comfortable convalescence, a greater strength of the wound, and, incidentally, a fine scar.

It is a modification of the Maylard or Bardenheuer incision, which, in turn, is an outgrowth of the approach devised by Pfannenstiel. The disadvantage of Pfannenstiel's incision is the rather limited exposure it affords; it is, therefore, not practicable in obese patients, nor is it suitable for the removal of large tumors or for any work deep in the pelvis.

The Maylard or Bardenheuer incision differs from the Pfannenstiel incision in that all the layers of the abdominal wall—from the skin to the peritoneum—are divided in the same transverse plane. Although it provides magnificent exposure, it has failed to gain favor in this country; its lack of popularity may well be due to the unwillingness of the surgeons to section both rectus muscles, in spite of the fact that the incidence of postoperative hernia following this incision compares very favorably with the end-results of the customary vertical incisions.

The modification to be described overcomes this objection, and combines the attractive features of both the Pfannenstiel and the Maylard-Bardenheuer incisions.

DESCRIPTION

The incision through the skin is made like its prototype—a curvilinear incision, beginning from one to two fingerbreadths below and medial to the anterosuperior iliac spine, crossing the midline, running almost straight and just within the upper pubic hair line, and terminating below the iliac spine of the opposite side (Fig. 1, *A*). It is developed through the subcutaneous tissue down to the aponeurosis of the external oblique muscle and the anterior sheath of the recti. The vascularity is variable, sometimes only a few vessels require ligation; generally, however, more clamping and ligating is necessary than with a vertical incision. At either end of the incision the superficial epigastric vein is usually encountered, divided, and ligated.

The anterior sheath of the rectus muscle is nicked on either side of the midline; it is then divided transversely with scissors, and the incision is extended laterally through the aponeuroses of the external and internal oblique muscles, thus exposing the underlying recti in the center, and the fascia transversalis and the peritoneum laterally. In the more central portion the aponeuroses of the oblique muscles are fused; but, as the incision is extended laterally, two separate layers will be recognized. The fleshy fibers of the internal oblique muscle come into view about two fingerbreadths from the anterosuperior iliac spine where the incision ends. In exceptional cases the muscle may be encountered farther medially, and since the direction of its fibers is the same as that of the incision they may be split bluntly. The lower flap of the rectus sheath is grasped on either side of the midline and separated by gauze dissection from the underlying rectus muscles as far as the pubic bones. In the midline a fibrous septum (part of the linea alba) extends from the deep aspect of the sheath between the contiguous margins of the two recti (Fig. 1, *B*.) This septum must be snipped with scissors, with care to remain deep to the aponeurosis to avoid button-holing that structure; the penalty of a slit in the sheath is a possible postoperative hernia. The pyramidalis muscles are next dissected from the recti.

Near their attachment to the pubis, the recti are fibrous, frequently entirely tendinous (Fig. 2a). They are cut at their very insertion into the pubis. Even in rare cases in which the muscle fibers are abundant, bleeding is negligible. The muscles are then reflected upward.

The peritoneal cavity is first entered at either end of the incision, under the lower flap of the rectus sheath. By the insertion of the index finger into the peritoneal cavity, the height of the bladder is ascertained, and the peritoneum is incised transversely about one fingerbreadth above the line of its reflection from the abdominal wall to the bladder. In the midline the urachus is divided, and the rare instances of its patency should be kept in mind. The incision, extending from one inferior epigastric artery to the other, is usually sufficient, but there is no contraindication to dividing one or both arteries.

In the closure of the incision the peritoneum is sutured in the customary fashion. The pyramidalis muscles are allowed to fall on top of the peritoneum without any sutures, or their apex may be sutured by a single stitch to the deep aspect of the recti. The ends of the rectus tendons are securely united with mattress sutures to the under surface of the rectus sheath (Fig. 2b). Even in the cases in which muscle fibers predominate at the end of the recti, a preponderance of fibrous tissue will be found in the midline and along both lateral margins. After the insertion of the midline suture the lateral edge of each rectus muscle is sutured as far laterally as possible, encroaching on the Hesselbach's triangle.

In the earlier cases an apparently more rational procedure was employed: the rectus tendons were not detached from the pubis, but a stump was left for subsequent reattachment. However, it was discovered that the sutures had a tendency to pull out of the distal-cut end of the tendons.

Reattachment of the recti is the only part of the closure which may prove slightly difficult. However, the table may be broken so as to flex the patient's pelvis on the trunk, thus approximating the structures to be sutured. If the operation is performed under general anesthesia, the latter, hitherto very light, must be deepened at this stage; the rectus muscles have retracted, and must be relaxed

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(Author of this paper is now overseas.)

to permit their reattachment without undue tension. It will be remembered that the recti are firmly attached to their anterior sheath; consequently, if the edges of the upper flap of the rectus sheath are grasped and pulled down, suturing of the lower end of the muscles will be greatly facilitated.

The aponeuroses of the oblique muscles are then closed in a single layer, care being taken to pick up both layers in the lateral portions of the wound. Superficial fascia and skin are sutured in the usual way.

ADVANTAGES

This incision offers several definite advantages.

The transverse diameter of the lower abdomen is about 25 per cent longer than the distance from the umbilicus to the symphysis pubis in the male and even longer in the female. Since the resultant exposure is proportional to the square of the axis, the transverse incision is capable of giving an operative field from one and one-half to two times larger than that afforded by the vertical incision. An additional advantage lies in having the center rather than the end of the incision over the operative field. Inasmuch as the overhanging fold of fat found in very obese patients is above the level of the transverse incision, it will not be in the way of the sur-

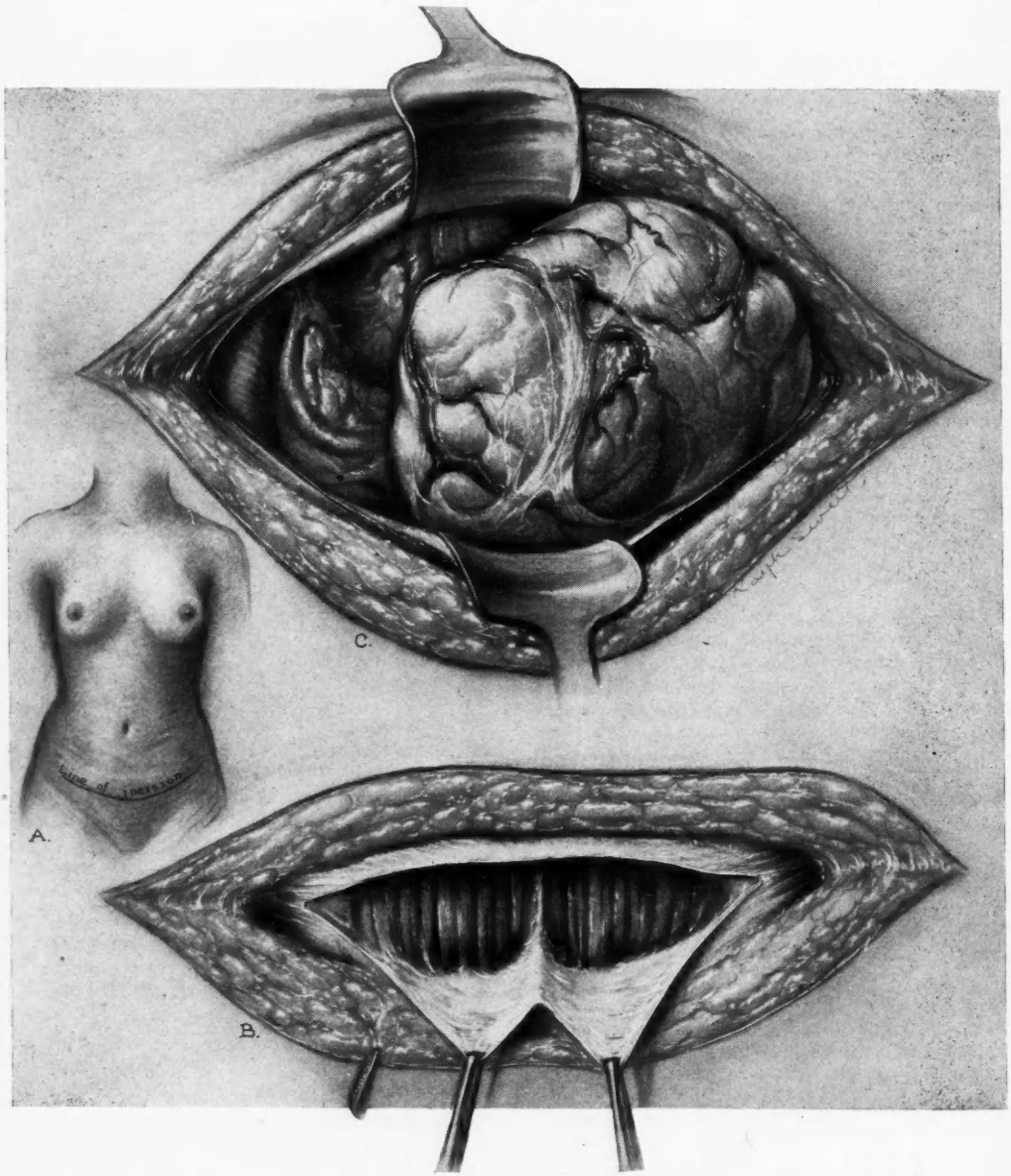

Fig. 1.—*A.* The line of incision. *B.* Elevation of the lower flap of the rectus sheath. *C.* The resultant exposure. The particular tumor was a large ovarian cyst, intraligamentous, filling the entire true pelvis and projecting into the false pelvis.

geon, thus appreciably decreasing the depth of the wound.

The exposure gives ready access to the lower sigmoid and the upper rectum, the region of the bifurcation of the aorta and the organs contained in the broad ligament (Fig. 1, *C*). Even in the male, the rectum can be mobilized as far as the end of the coccyx, under direct vision and without the handicap of working in a deep funnel. Surgeons who favor the preservation of the anal sphincter, as in the Devine procedure for excision of carcinoma at the rectosigmoid junction, will be able to remove more of the rectum, and to achieve an anastomosis deeper in the pelvis than can be accomplished with the use of the vertical incision.

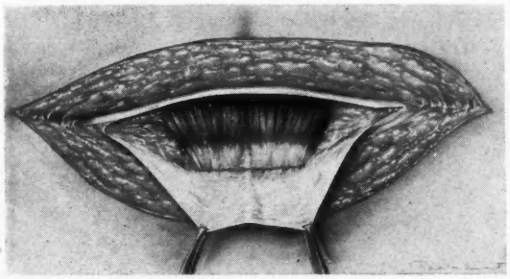

Fig. 2a.—The lower flap of the rectus sheath, elevated to expose the tendinous ends of the recti. The dotted line indicates where they are to be divided. Note the fibers of the internal oblique muscle showing at either end of the incision in the fused aponeurosis of the oblique abdominal muscles.

The incision described is not intended for general exploration of the abdominal cavity, but it will permit palpation of the liver and the performance, if desired, of the incidental appendectomy, unless the appendix is located unusually high. I have heard from other surgeons that large pelvic tumors extending to the level of the umbilicus have been delivered through this incision without difficulty.

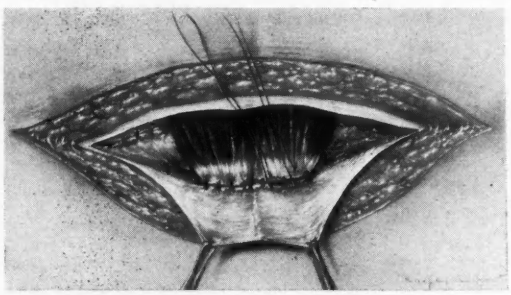

Fig. 2b.—Showing suturing of the recti to the lower flap of the rectus sheath. A second row of sutures may be inserted if desired.

The strength of the abdominal wall following this approach results from four factors: (1) no part of the muscle is denervated—the pyramidalis is of little account; (2) the aponeuroses of the oblique abdominal muscles, the recti muscles, and the peritoneum are divided at different levels—in a staggered incision, the layers of the abdominal wall are not weakened in the same place; (3) all the sutures are taken in tendinous structures which offer more secure anchorage and more reliable union; and (4) the direction of the pull of the oblique abdominal muscles is parallel to the direction of the incision in their aponeurosis. Consequently, the line of suture in this most important layer of the anterior abdominal wall is subjected neither to the constant strain of muscle pull, nor to the sudden disrupting jerk during a paroxysm of coughing. The incidence of evisceration or postoperative hernia should be negligible.

A question might arise as to why a powerful muscle like the rectus abdominis does not tear loose from its suture line once the patient begins to use it. The answer lies in the fact that the recti muscles become reattached to their sheath, not by the cut end, but by their entire anterior surface. In addition, since the recti are segmented, the greater part of the muscle pull is communicated to the anterior rectus sheath through the interscriptions; thus, the newly established union between the rectus muscles and their sheath will be subjected to the strain of the pull of only about the lower fifth of each rectus muscle.

The low abdominal incision is also attractive from the point of view of anesthesia. As the incision is below the level of the eleventh segment of the thoracic cord, spinal anesthesia need not extend higher; accordingly, there is less depression of the blood pressure. If general anesthesia is employed, it may be light, except when the rectus muscles are being reattached; no muscular relaxation is required at other times because the contraction of the muscles does not tend to close the wound. The edges of the wound gape without the aid of retractors. Very little packing is required to keep the small intestines out of the field, and for this reason there is less tendency to postoperative distention. The possibility of performing a cesarean section with minimal anesthesia makes for greater safety for the infant.

The lower abdomen is not used much in respiration even by men; consequently, the pain of a low abdominal incision is not aggravated by breathing and will have almost no inhibiting influence on respiration. Since the incision is relatively painless, the requirement of narcotics is diminished; a pillow placed under the patient's knees for the first two days will further reduce postoperative discomfort. No adhesive strapping is needed above the iliac crest, thus further promoting better pulmonary ventilation. The surprising freedom with which the patient moves in bed after operation can be easily explained by the consideration of the anatomical factors involved: the patient turns by the use of the oblique abdominal muscles; since they do not tend to pull the incision apart, their contraction does not produce pain. These same muscles are the ones primarily concerned in coughing; therefore, the patient has less dread of expectorating. The combination of relatively painless motion, respiration, and coughing leads one to expect a very low occurrence of pulmonary complications.

For those patients who judge the merits of an operation by the appearance of the scar, this incision is particularly desirable; the part which is not hidden by the pubic hair follows the natural skin lines and will eventually merge with these lines.

I have information concerning approximately one hundred of these operations that have been performed by surgeons in different parts of the country, and the results have been eminently satisfactory.

The question of how calamitous infection would be has naturally been raised. To my knowledge, there have been three infections to date; they were all limited to the subcutaneous fat, and cleared up promptly. In view of greater vascularity of this region, one may expect a lower incidence of infection here than in other locations in the abdomen.

Until we gain more information from inadvertent infections, the use of this incision is not advocated for patients in whom infection would be a likely complication. In abdominoperineal resections and other pelvic procedures with potential contamination of the wound, local use of sulfanilamide in the properitoneal, and particularly in the subcutaneous fat, is advisable.

SUMMARY

A new transverse low abdominal incision is described which has advantages in all the stages of the operative treatment. During the operation, it affords better exposure with lighter anesthesia. During the early postoperative days, it makes for greater comfort by decreasing abdominal distention and decreasing pain on deep respiration, coughing, sneezing, and moving; the incidence of pulmonary complications is, consequently, less. Ultimately, as well as immediately, the wound is strong because no muscle is denervated, the incision is staggered, all the sutures are taken in aponeurosis or tendon, and the direction of the main muscle pull is parallel to the direction of the incision; these factors should practically eliminate dehiscence of the wound in the early days, or development of a postoperative hernia subsequently. The good cosmetic result appeals to the patient as much as the other features do to the surgeon.

490 Post Street.

TROPICAL DISEASES*

LIEUT. COMMANDER RICHARD F. MCLAUGHLIN
MC-V (S), U. S. N. R.
Oakland

ONE of the finest chapters in the history of the United States Naval Medical Corps is being written today by the extraordinarily competent handling of the tropical disease situation by the men in the advanced units. The hospitals on the West Coast are greatly indebted to these men for their brilliant and sometimes inspired clinical reports.

* Read before the Second General Meeting at the seventy-second annual session of the California Medical Association, Los Angeles, May 2-3, 1943.

The opinions or assertions contained therein are the private ones of the writer and are not to be construed as official or reflecting the views of the Navy Department or the Naval Service at large.

MALARIA

Malaria is, of course, numerically our greatest problem, and its therapy continues to be not entirely satisfactory. A new departure in therapy first used by Lieutenant Kennedy at the Letterman Hospital is very promising. We have used several forms and combinations of therapy. The form that to date has given us the smallest number of recurrences is a combination of larger doses of atabrine, standard doses of quinine combined with the use of adrenalin and ephedrine. Our use of intramuscular doses of atabrine to secure an initial high blood level and maintenance of that level by continued oral use is insufficient, both as to number and length of time, to permit any conclusion. The intravenous route for quinine administration has achieved brilliant results for us in cerebral, and some of the other atypical malarias seen in our hospital. In our experience 90 per cent of the cases have been benign tertian, 6 per cent malignant tertian.

The clinical manifestations and immunological reactions have given some indication that the benign tertian being seen today may be a separate type from the usual strain that has been seen. Further work is now being done by Dr. Paul Michael on this problem. We have one case, a man who had been on Samoa only. This is the only case reported from this area.

INTESTINAL PARASITISM

Intestinal parasitism, though showing a high total number of cases, is not alarming when considered on a census percentage basis; as a matter of fact being almost within the same percentage limits as seen in this country. The slide shows the percentage observed to date in our hospital. Fourteen per cent of examined stools showed pathogenic forms. They have not been a serious problem.

PARAGONIMIASIS

Paragonimiasis, a rather unusual disease, was detected in our armed forces by Dr. John J. Miller, Jr. This disease has also been known as pulmonary distomiasis and endemic hemoptysis. Both of these names are open to criticism as being misleading. The infection may be found in any organ of the body, is not necessarily characterized by pulmonary involvement, and hemoptysis need not be present, though the lungs are involved. It is seen commonly in Japan, Korea, Formosa and in many isolated Far Eastern foci, including the Philippines and, with the advent of this war, Samoa.

Ova are expectorated or passed in the feces of infected man or animal, mature and hatch in water, liberating a miricidium. This penetrates the soft parts of a snail, develops into a cercaria, or the second generation form. These cercaria penetrate the chitin of the crayfish, cause a generalized infection and become encysted. These encysted forms, if eaten by man, either raw or improperly cooked, penetrate the intestinal wall, migrate through the diaphragm to the lungs, and from there to any part of the body. Some of the young worms may not penetrate the diaphragm. They have been found fully grown in the peritoneal cavity. Direct infec-

tion has been accomplished experimentally without the miricidium passing through snails and crayfish. This raises the question of the possibility of natural, direct infection occurring from the consumption of poorly prepared parts of infected animals.

Musgrave, in describing the pathology, demonstrated the flukes and ova in the lungs, pleural and peritoneal cavities, the heart, pericardium, liver, pectoral muscles, intestinal wall, the deep and superficial lymphatics, appendix, meninges and choroid plexus. He concluded that this general distribution was accomplished through the blood stream and lymph channels. He described nonsuppurative, suppurative and tubercle-like lesions.

Paragonimiasis, though generally chronic, may have a fulminating, rapidly fatal course, especially if complicated by a preëxisting disease such as tuberculosis.

The *symptomatology,* usually first presented, is referable to either the chest or abdomen, or due to lymphatic involvement. When the chest is involved, it is usually characterized by a chronic, productive cough; the sputum being thick, spotted with brownish flecks and frequently streaked with blood. One of our patients gave a *history* of repeated massive hemorrhage necessitating transfusion; this had not been previously described. Frequent, almost constant, pleural pain is the rule.

Physical findings vary, but most frequently resemble those of bronchitis. The ova found in the sputum are described as thin-walled, doubly refractile eggs measuring from 62 to 98 mu. They contain an operculum and a dark nucleus, surrounded by golden brown yolk cells. Fever varies with the course of the disease. A leucocytosis, with or without an eosinophilia, may or may not be present. In the abdominal type there is usually a dull generalized pain and tenderness with some rigidity. Not infrequently there is an increased area of liver dullness due to the presence of the fluke in the biliary passages. Bloody diarrhea is frequent. Psoas abscess resembling the tuberculous has been described. In the lymphatic type, local symptoms due to a lymphatic hypertension caused by either a partial or complete regional obstruction may occasion biopsy as means of differentiation from filariasis.

There is no specific *therapy.* Sulfonamides are used for contaminating organisms. Phenodiazine has been used, but the results are not encouraging.

FILARIASIS

The most interesting of all the tropical diseases seen by us has been filariasis, caused by the Filaria or Wuchereria bancrofti. This organism has a wide distribution in the tropical and subtropical regions of Africa, India, China, Australia, South Pacific islands, certain parts of South America, the Caribbean Islands, and in Charleston, South Carolina. The adult females average 60 mm. in length, the male 30 mm., while the microfilaria range from 150 to 300 micra in length and 7 micra in diameter.

Under well-controlled conditions forty-four different mosquitoes may serve as partial or complete hosts for the development of the mature larvae. Practically, however, the Culex Quinquefasiatus, Aedes Variegatus, and the Culex Pipiens account for the vast majority of intermediary hosts. The microfilariae, injected by the mosquito, undergoes three metamorphic changes, migrates to the labellum, and as the adult larvae can then cause the infection. After the bite, the larvae, being lymphotactic, enter the skin and lymphatics, and are carried to the deeper lymphatics, where they develop into the mature worm, mate, and parturate.

The *clinical picture* seen in these cases is that of a subacute lymphangitis, recurrent, linear, elevated, hyperemic, and at times very painful. It proceeds peripherally, leaving during the stages of remissions some distinct induration of the lymphatic channels, with enlargement of the lymph nodes. It may involve one or both upper extremities, one or both lower extremities, and in a certain percentage, the spermatic cords and testicles. Combinations of these may occur in the same patient.

Classically, this infection is supposed to be divided into four phases, namely: the incubation period; the second, or symptom-free period; next the lymphangitic phase; and, finally, the chronic stage of Elephantiasis. We have observed the first three phases, but not the classical elephantoid phase. To date, no microfilariae have been seen in the peripheral blood.

Thirty per cent have been proved out by biopsy studies with the demonstration of the adult or adolescent worm, both male and female. The remainder of biopsies, although not actually showing the worm, were presumptive, in that the classical granulomatous lesion of this disease was observed, with typical granulation tissue and eosinophilic infiltration. The symptoms seen in the lymphangitis stage are probably due both to mechanical blocking by filariae, together with an allergic reaction between the human host and the products of the worm. Culturally, our cases were sterile except in one instance, where the lesion was superficial and communicated with the outside skin.

It is felt that these patients will be cured spontaneously simply by foreign-body engulfing of the worms as a natural course of body resistance. Relapses, of course, will follow before this cure will be effected. There is as yet no specific therapeutic agent known, although most drugs have been tried. It had been our reaction that surgical removal of superficial foci has resulted in improvement of the patient. Surgical intervention of the spermatic cord lesions, however, is strongly advised against, as lesions of this nature usually undergo exacerbations after this procedure.

Discussion.—The laboratory diagnosis of endemic filariasis in the natives, as seen in Samoa and other islands of the South Pacific, usually offers little problem. The finding of the microfilaria of filariae bancrofti in the blood is a most usual event in large numbers of the natives of these islands. The incubational period of approximately eight months to one year from the time of infection to the appearance of the microfilaria in the blood, however, renders the proof of infection in the military

personnel a somewhat more difficult problem. The differential diagnosis, from the clinical point of view, is obviously fraught with many complexities. Atypical Malaria brucellosis may simulate Filariasis. Moreover, the finding by the laboratory aides of Paragonimus ringeri in several patients returned from Samoa, discloses another disease which may simulate Filariasis in its early forms. As a matter of fact, these diseases may even exist simultaneously in the same patient. Therefore, every possible laboratory aid to the diagnosis of filariasis must be brought into use. Space does not permit the various tests which may be used in the diagnosis or ruling out of such allied conditions as are named above, except that it should be born in mind that Paragonimus ringeri, or P. westermanii, may lodge in the lymphatics of the extremities or spermatic cord, and in doing diopsies, care should be used in not overlooking any possible presence of ova. Stool and sputum examinations in this condition are also of great aid.

In approaching the *diagnosis* of Filariasis in men who have been in endemic localities, the time interval is of first importance. It is unlikely that microfilaria will be seen in the blood or hydrocele fluid of men with incubation periods of less than eight months to a year. Search should be made, however, even in doubtful cases. Ordinary blood smears, preferably around eleven o'clock at night, should be made, using thick smears. The concentration technique of Knott, however, may be used both in day and night examinations. This technique employs the use of 1 c.c. of blood in 10 c.c. of 2 per cent formalin. This is allowed to sediment for from twelve to twenty-four hours, and the sediment used for thick smear preparations. Giemsa, Wright's or Loeffler's methylene blue-eosin stains may be used. Unfortunately, this rather simple diagnostic method is of little help in the patients who may be in the incubational asymptomatic, or early acute stages before the worms have become sufficiently mature to produce microfilaria.

In the lymphangitic stage the most valuable aid is the removal of tissue for biopsy examination. Certain important points in this procedure should be followed, namely, choice of site for biopsy, and the use of serial sections, if single sections fail to reveal the adult or adolescent worms. As the worms apparently seem to follow a retrograde movement distally in the lymphatic chains, the choice site of the biopsy should, if possible, be the most distal lymphatic involvement. Biopsy of the cord-like structure is more desirable than the lymph node itself, as lymph nodes may show only a drainage type hyperplasia with eosinophile infiltration and edema. There is a rather characteristic granulation tissue produced by the lodgment of the worms in the lymphatic or other soft tissues. A tuberculoid reaction is observed around the engulfed worms, many of which may be in the process of death or absorption. In identifying the mature or adolescent worms, care should be observed in recognizing certain aspects of the morphological characteristics. The cuticle of Wucheria bancrofti is smooth, the spicules are unequal, and in the female the uterus is double on cut section. The vulva of the female is preëquatorial, usually in the esophageal region. The posterior end of the male is sharp, with a ventrad curve, while in the female it is blunt. If a suitable biopsy is taken from the soft tissue lesions, little difficulty should be encountered in establishing the diagnosis.

Other tests, now not commonly used, but of distinct help, are the alexin-fixation and the intracutaneous reactions. Alcoholic and aqueous antigens derived from fresh or dried Dirofilaria immitis and Onchocerca vuloulus.

There is no specific treatment. Local measures, as wet packs, elevation, etc., are used for the relief of the acute lymphangitis. Surgery is resorted to in the elephantitic stage.

A typical report from the department of pathology is as follows:

Microscopic.—The microscopic sections show lymphatic tissue undergoing endothelial and fibrous hyperplasia. Several dilated lymphatic channels can be seen containing adult filarial segments, many of which are undergoing early calcification. The endothelial cells proliferate radially from the channels, and the nuclei of the cells nearest the hub show pyknosis. This reaction causes a picture simulating palisading with formation of pseudorosettes. In same places the fibrous tissue is young and immature, composed of proliferated fibroblasts, while in the others it is old, homogeneous, hyalinized. Round cells are numerous and extend out into the fat and muscle. Endothelial cells occasionally are fused and show pseudo-giant cell formation. Eosinophiles are numerous and in many places the eosinophilic granules have broken out of the cell membranes, but may be seen scattered as fine, red, dust-like particles between the cells. There appears to be some attempt to collateral lymph circulation.

Oakland Naval Hospital.

VIRUS PNEUMONIA: A REVIEW OF THE PATHOLOGY*

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San Francisco

SECONDARY bronchopneumonia is of fairly frequent occurrence, but primary bronchopneumonia, except in pandemics of influenza or streptococcal epidemics, is rather rare. However, in recent years there has been a growing number of reports of pulmonary disease of undetermined origin. In 1935, Bowen [1] called attention to a form of pneumonitis observed in troops in Hawaii which produced but few clinical signs except for râles, and was mild, but x-ray showed spotty shadows extending into the lower lobes. Cough and low leukocyte counts were characteristic. Cultures from the

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sputum gave no indication as to the etiology. Allen,[2] in 1936, described a similar mild form of pneumonia at Fort Sam Houston, where the physical signs were scant but x-ray revealed areas of pulmonary consolidation. All recovered and the etiology was unknown. Smiley, Showacre, Lee, and Ferris,[3] in 1939, described a similar form of pneumonia spreading through the student body at Cornell University, with eighty-six cases during a period when influenza was not pandemic. All recovered. They described it as an interstitial pneumonia not due to pneumococci. In 1938, Reimann [4] of Philadelphia reported eight cases of acute infection of the respiratory tract with atypical pneumonia and suggested a virus as the cause, but he did not believe that the disease was influenza. Stokes, Kenney, Shaw,[5] and Francis, studying nose and throat washings and blood from two of Reimann's cases, obtained a filterable agent capable of producing pneumonia and encephalitis in mice, guinea pigs, and possibly ferrets, but the strain was eventually lost in animal passage. The guinea-pig lungs contained bluish-gray areas of firm, patchy bronchopneumonia. Microscopically, the inflammatory changes were of both lobar and peribronchial distribution. The bronchiolar epithelium was piled up into swollen folds with vacuoles and the lumen contained mucopus. The wall of the bronchi was thickened and highly vascular. The alveolar exudate was made up chiefly of mononuclear cells and fibrin, with occasional clumps of polymorphonuclears, but no destruction of lung tissue or abscess formation. Serologic study of Reimann's patients indicated that the illness was not due to epidemic influenza virus. Animal studies indicated that it was not the psittacosis virus or that of meningopneumonitis, but rather some new filterable agent which was the cause of the disease in Reimann's patients. Maxfield,[6] in 1939, analyzed sixty-three cases of an atypical leukopenic pneumonia occurring in epidemic form with unknown etiology and complete recovery. Murray,[7] in 1940, published an excellent account of 146 cases of atypical bronchopneumonia observed among the students at Harvard. The average case presented a normal or slightly elevated leukocyte count. The initial counts were 5,000 to 12,000 with 70 to 75 per cent polymorphonuclears. In about one-third of the cases there was a curious rise in the count during convalescence, occasionally reaching 17,000 to 20,000. While this might be taken to indicate the onset of some complication such as empyema or lung abscess, none appeared in this group. The convalescence was rapid and no deaths occurred. The majority of sputa contained no pneumococci but a variety of organisms. Blood cultures were negative. The urines were negative except for occasional transient albuminuria and, very occasionally, small numbers of red cells in the centrifuged sediment. Attempts to isolate a filterable virus were unsuccessful.

Weir and Horsfall,[8] of the Rockefeller Foundation, isolated a virus capable of producing pulmonary consolidation in the wild mongoose from throat washings of patients with acute pneumonitis. This virus differed from other viruses known to cause infections of the respiratory tract in man. The lung lesions in the mongoose were circumscribed areas of plum-colored consolidation with gelatinous consistency and generalized pulmonary hyperemia. Microscopically there was extensive edema, distending the alveolar spaces and thickening the septa. The sparse cellular exudate was almost entirely of mononuclear cells. The bronchial epithelium was well preserved and the lumina contained protein-rich edema fluid.

Kneeland and Smetana,[9] in 1940, reported fifty-two cases of primary bronchopneumonia in New York with one death. The leukocyte counts early in the disease were only slightly elevated, if at all, with a rise in the number later in the disease. The sputum was scant and rarely rusty and, from a bacteriological standpoint, was entirely comparable to that of healthy individuals. They were impressed by the lack of secondary bacterial infection of the lungs. Whereas the influenza pandemic of 1918 gave abundant proof that influenza encouraged all sorts of bacteria to invade lung tissue with disastrous results, the reverse seemed to be true in their 1940 series. The urine contained none or a slight amount of albumin with normal renal function. There was some evidence of liver changes in a few of the severe cases, as indicated by slight jaundice, reversal of the serum albumin-globulin ratio and bromsulphthalein retention. The single death was a female of 47, who was ill ten weeks with pneumonia of both lungs. No pneumococci were recovered from the sputum. She did not respond to sulfapyridine. There was no leukocytosis. The complicating features were thrombophlebitis of the legs, anemia, hypoproteinemia, and heart failure. The lungs contained many small, pink to gray, airless patches projecting slightly above the surface with moderate intervening emphysema. The bronchi were congested and contained thick mucopurulent exudate which yielded Type 10 pneumococci. Microscopically there was a varied lung picture indicating different stages of the disease. The earliest lesions were a hemorrhagic exudate of red cells, blood plasma, and a few mononuclear wandering cells within the alveoli and a mild infiltration of the septa by similar cells. Later stages showed an organization of the alveolar exudate, with the spaces growing smaller and the septa thicker. Many alveoli were solidly filled with mononuclears containing fat droplets and hemosiderin granules. The septal thickening was due to fibrosis and mononuclears. The mucosa of the larger bronchi and trachea was densely infiltrated by polymorphonuclears and mononuclears, and the lumen contained mucopurulent exudate. No inclusion bodies were seen in any of the sections. Moderate-sized branches of the pulmonary arteries showed an extensive, eccentric necrosis of the walls which were infiltrated by polymorphonuclears, mononuclears, and eosinophils, extending into the adventitia. The spleen gave the picture of an acute splenic tumor. The liver had areas of focal necrosis and large mononuclears scattered through the

lobules. The kidney findings were interpreted as a nephrosis, probably due to medication with sodium sulfanilate. Although the etiology of the disease which they reported was unclear, they found the virus hypothesis the most attractive.

Longcope,[10] in 1940, reported thirty-two cases of a form of leukopenic bronchopneumonia which he called "Variety X." Blood cultures, agglutination tests, and sputum examinations yielded no indication of the etiologic agent. Two of this series did not recover:

One was a man of 38, who died in seven days with marked cyanosis. Autopsy revealed a mitral stenosis and insufficiency of rheumatic origin. The lungs were heavy and boggy with no pleurisy. Large areas in both lungs felt almost consolidated, but cut sections showed them rather filled with fluid than consolidated, and there were small, 2-4 centimeters, patches of dark, red, raised areas of consolidation. Microscopically the bronchi contained thick exudate of polymorphonuclears and round cells. Their walls were infiltrated with similar cells. The surrounding alveoli were solidly filled with mononuclear cells with no polymorphonuclears. Bacterial stains revealed no organisms. Elsewhere the alveoli were air-bearing or filled with edema fluid. Inoculation of lung tissue into mice and ferrets produced no positive results.

The second fatal case was a man of 40, who had been under observation for several years for myocardial failure from rheumatic heart disease involving the aortic valve. The initial leukocyte count was 4,600 with 90 per cent polymorphonuclears with a gradual rise to 10,400. The sputum contained no organisms pathogenic for mice. He died in eleven days. Autopsy: The lungs were dark red and hemorrhagic, with a fine fibrinous pleurisy over an area of consolidation in the left lower lobe. The bronchi were filled with tenacious mucus. Microscopically there was hemorrhage, edema fluid, macrophages and polymorphonuclears in the peribronchial alveoli, sometimes showing organization. Some of the radicles of the pulmonary artery showed necrosis and cellular infiltration of the wall. Cyanosis was a prominent feature of these two patients, both of whom had chronic rheumatic heart disease. The etiology of Longcope's "Variety X" bronchopneumonia is unknown, but he believed that it was some form of virus.

Adams,[11] in 1941, reported thirty-two cases of primary virus pneumonitis of infants in Minneapolis during a three-month period, with nine deaths. At autopsy the lungs were congested with scattered nodular areas of hemorrhagic pneumonia. Microscopically there was necrosis and ulceration of the bronchial epithelium with sloughing into the lumen, and patches of peribronchial infiltration of mononuclears. Polymorphonuclears, lymphocytes, and large mononuclears filled the alveolar spaces. All nine cases showed characteristic cytoplasmic inclusion bodies in the bronchial epithelial cells. The cytoplasm was often vacuolate with the inclusion body near the nucleus staining red with hemotoxylin and eosin. Fresh lungs were sent to Francis, who was unsuccessful in isolating a virus. Serum from ferrets inoculated with this material failed to show antibodies capable of neutralizing influenza virus and inclusion bodies have not been found in influenza. Adams concluded that the epidemic of pulmonary disease which he described was due to a virus as indicated by its high degree of contagiousness, by its distinctive symptomatology and pathology and by the failure to identify a causative bacterium.

Dyer, Topping, and Bengtson[12] report an epidemic of pneumonitis comprising fifteen cases among 153 employees in one building of the National Institute of Health in the spring of 1940. The causative agent was identified as the rickettsia of "Q" fever. All but one patient recovered. The disease was characterized by normal leukocyte counts with more than 70 per cent polymorphonuclears, negative blood cultures and agglutination tests, no consistent sputum flora, minimal chest findings by physical examination, but definite signs of bronchopneumonia by x-ray. Strains of "Q" fever virus had been carried in animals and tissue cultures in this building since 1938. Whether or not this served as a source of infection is open to question, since the personnel of this unit were spared and the cases were widely distributed throughout the building. Lillie, Perrin, and Armstrong[13] reported the pathologic findings of the one death from "Q" fever. The lungs were congested and edematous basally with firm gray granular consolidation of the right upper lobe. The spleen was enlarged, soft, and flabby. Microscopically there was a diffuse alveolar consolidation, with fibrin as the chief component enmeshed, in which were varying numbers of lymphocytes, plasma cells, and large mononuclears. Red cells were numerous in scattered alveoli, but polymorphonuclears were rare. Proliferating fibroblasts and alveolar epithelium were prominent. The alveolar septa were moderately thickened with fibrous tissue, lymphocytes and large mononuclears, and the capillaries were empty. The bronchioles were usually completely occluded by exudate. This pneumonic process appears to have been essentially the same as that described by Kneeland and Smetana,[9] and Longcope.[10] The spleen showed congested pulp, few polymorphonuclears, and moderate numbers of large lymphoid and plasma cells. No rickettsia were seen. Eight rhesus monkeys inoculated with the four strains of "Q" fever virus isolated from this epidemic presented essentially an identical picture to the human case.

REPORT ON SAN FRANCISCO CASES

Through the kindness of Dr. A. M. Moody, I shall briefly describe six cases of influenza-like bronchopneumonia occurring early in 1940 in San Francisco which were closely connected epidemiologically. Three of the six patients died after a brief illness. The physical chest findings were scant, but x-ray studies showed bronchopneumonia. Autopsies of two of these revealed a pseudolobar pneumonia with edema, hemorrhage and irregular

areas of tannish-gray, moist consolidations with emphysematous margins. The spleens were enlarged and soft. Microscopically, the pulmonary alveoli were filled with serum and a coarse network of fibrin containing large mononuclear cells, red cells, and only rare polymorphonuclears. The alveolar septa were thickened due to congestion, mononuclear infiltration and swollen epithelium. (Fig. 1.) Some of the bronchi contained desquamated epithelium, fibrin, mononuclears, and many polymorphonuclears; however, there was only a slight inflammatory reaction present in their walls. Specimens of the lungs, liver, and spleen were sent to the Virus Research Laboratory of the California State Department of Public Health and the findings were reported by Eaton, Beck, and Pearson [14] as a virus antigenically related to psittacosis. They described the lungs of the inoculated mice as showing many small bluish-gray focal lesions. Microscopically, there were dense accumulations of mononuclear cells with a few small patches of polymorphonuclears in the alveoli. The septa were swollen. Other alveoli contained fluid. In August, 1940. Moody examined a similar patient expiring in another San Francisco hospital where autopsy material submitted to the Hooper Foundation was found to contain the psittacosis virus. Foord,[15] in 1934, reported a proved case of psittacosis in Pasadena with pathologic findings practically identical with those described above.

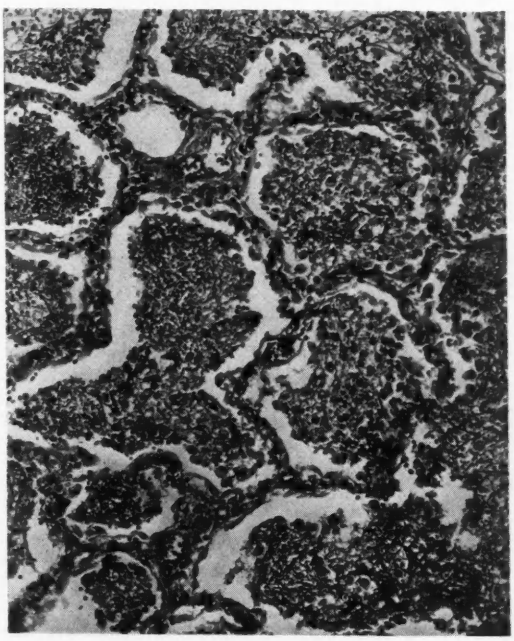

Fig. 1.—Microscopic section of lung showing mononuclear cells, erythrocytes and fibrin in alveoli (x 200).

In 1935 [16] and 1937,[17] Cheney described a puzzling febrile illness observed in twenty cases in the San Francisco Bay district, the etiology of which was unknown. The findings were so like those seen in cases of dengue fever that this diagnosis was seriously considered. He compromised by calling it a dengue-like fever. He expressed the opinion that it seemed most likely that the etiology of the disease was a filterable virus. Although no virus was isolated, he was able to reproduce the disease by intravenous injections of blood from patients into four volunteer persons. In reviewing the clinical picture of these cases reported by Cheney, it seems most probable that it was the same illness that we now know as virus pneumonia.

During the past year Cheney and Gardner[18] have compiled records of twenty-eight cases of so-called virus pneumonia in Stanford Hospital in San Francisco characterized by fever, initial leukopenia or normal leukocyte counts with polymorphonuclears somewhat higher than normal, and minimal chest findings by physical examination but definite areas of shifting pulmonary consolidation by x-ray. Sputum examinations revealed only the usual flora. Prostration was often severe, but there were no deaths. Sera of eight of these patients were studied by the Weil-Felix agglutination test and seven proved positive. The one negative test was made ten months after recovery. This test is widely used in the laboratory diagnosis of rickettsial diseases. The finding of seven positives out of the eight sera tested is certainly highly suggestive that these patients may have been ill with a rickettsial disease, and further investigations are now in progress. Agglutination tests for "Q" fever were run on several of these patients and found negative. Complement-fixation studies for virus made by Eaton on bloods from eight other patients in this series were negative.

DISCUSSION

In reviewing these recently reported outbreaks of primary bronchopneumonia, there is noted a marked similarity of clinical history and laboratory findings. In the main, no specific etiologic agent has been isolated, but the diseases possess many features which indicate that they are probably caused by some virus or viruses. The pathologic changes in the lungs of the few cases coming to autopsy are quite similar to those of known virus etiology and are characterized by alveolar exudate consisting largely of mononuclear cells, with polymorphonuclears conspicuously rare. In a small group of cases in San Francisco, a virus antigenically related to psittacosis was found responsible for the pneumonia, and the mortality rate was very high (50 per cent). The Washington epidemic [12] was caused by "Q" fever virus, resulting in only one death. The viruses isolated at the Rockefeller Institute [8] and in Philadelphia [5] have not as yet been identified. The same is true for the inclusion bodies consistently found in the Minneapolis epidemic[11] in infants, which carried a mortality rate of 20 per cent. It seems obvious that several viruses are responsible for producing quite similar disease pictures. Many of the reports refer to the occurrence of the disease among college students, hospital personnel or in garrisoned troops, and there is

abundant evidence that the infection is readily transmitted.

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(References continued on page 240)

CLINICAL NOTES AND CASE REPORTS

FECAL IMPACTION

REPORT OF UNUSUAL CASE

ANGELO M. MAY, M. D.

AND

EMILE TORRE, M. D.

San Francisco

IT is desired to report an unusual case of fecal retention.

REPORT OF CASE

CASE 1.—Mrs. F. G. came to our attention on February 24, 1942. She gave no unusual history other than the progressive enlargement of her abdomen over a period of two years. On the patient's word, no bowel movement had been expelled for a period of a year and a half.

The patient was a member of a family which included mental defectives, and her own word could not be relied upon; however, competent members of her family expressed the certainty that, for at least the last six months, the patient's story was correct.

Physical examination revealed an emaciated woman of 52, with an abdomen enlarged to the size of at least a full term pregnancy. Rectal examination revealed a large ovoid mass, reaching from beyond the rectum to the costal angle.

As the uterus was movable, it was felt that the probable diagnosis was that of a large ovarian cyst. The patient's story of obstipation was believed untenable.

Operation was performed on February 26, 1942, at which time the lower abdomen was opened through a midline incision. There came immediately into view a large, firm mass which had the appearance of a mammoth ovarian cyst, which extended far into the pelvis and above the xiphoid. There was no possibility of delivering the mass through the wound, so a trocar was inserted to ascertain the properties of the contents. No fluid escaped, and when the trocar was removed, substance resembling inspissated fecal material was found in the shaft of the instrument.

The opening in the mass was further enlarged and the true nature of the tumor became apparent. The descending colon from the splenic flexure to the sigmoid had become enormously dilated with feces, the bowel wall thinned to a cyst-like appearance. The patient had not exaggerated her complaint, for a bucket-full, or approximately five gallons of inspissated fecal material were removed. Search was made for an obstructive growth but none could be found. After removal of its contents, the bowel contracted down to a semblance of its former self, although it remained approximately three times the diameter and thickness of adjacent colon. The opening in the bowel was closed with inverting gastro-intestinal chromic suture. A loop colostomy was brought out above the metamorphic bowel, as it was apparent the dilated bowel was not ready to resume peristalsis. Eight grams of sulphanilamide were placed in the abdomen to prevent infection. The patient's recovery was uneventful. The colostomy was opened on the second day.

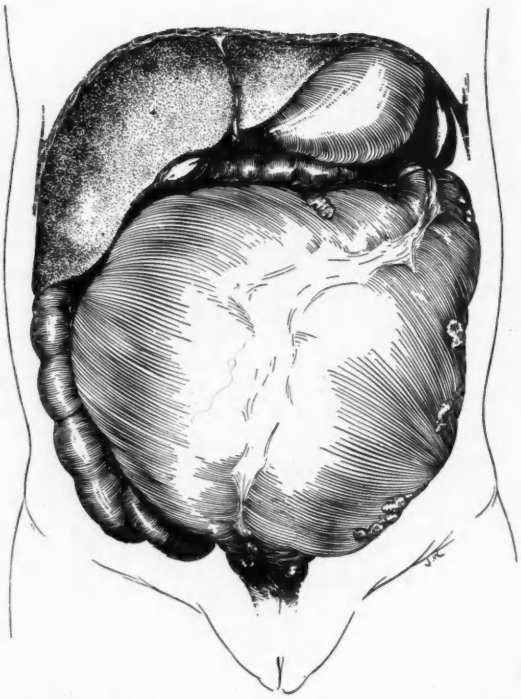

Fig. 1.—Showing enormously dilated descending colon filled with fecal material.

On the tenth to the twelfth day, the septum was crushed and fecal matter was thereafter passed into the lower segment of bowel and expelled per anus.

On the thirty-second day, the patient developed an intussusception of her large bowel, the double loop extending for a distance of 12 inches. This was reduced, however, with ease, and two days subsequently the colostomy closed and buried beneath the external oblique fascia.

Since this time the patient has had normal bowel movements, and has improved in physical appearance and strength to normal of her age.

COMMENT

This case, it is felt, demonstrates the extreme of fecal retention and the possibility of survival without defection over a long period of time. Because of the recovery made and the ultimate restoration of normal bowel activity, the authors feel that this case was a true fecal impaction, rather than a megacolon of the Hirschsprung type.

450 Sutter Street.

CALIFORNIA MEDICAL ASSOCIATION

This department contains official notices, reports of county society proceedings and other information having to do with the State Association and its component county societies. The copy for the department is submitted by the State Association Secretary, to whom communications for this department should be sent. Rosters of State Association officers and committees and of component county societies and affiliated organizations, are printed in the front advertising section on pages 2, 4 and 6.

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CALIFORNIA COMMITTEE ON PARTICIPATION OF THE MEDICAL PROFESSION IN THE WAR EFFORT

Mobilization of the Emergency Medical Service on Air Raid Alerts

OFFICE OF CIVILIAN DEFENSE
Washington 25, D. C.

Circular.—Medical Series No. 33. Issued on September 13, 1943.

To: Regional Directors and Regional Medical Officers.
FROM: Dr. George Baehr, Chief Medical Officer.

Attention is directed to Operations Letter No. 139, subject: Mobilization and Demobilization of Civilian Protection Forces. This Circular reviews the timing of mobilization of Units of the Emergency Medical Service in accordance with the Operations Letter.

YELLOW WARNING

1. *Chief of Emergency Medical Service and Deputies*

The Chief of Emergency Medical Service and his Deputies assigned to duty at Control Centers should receive the yellow warning and proceed immediately to their designated posts.

2. *Hospitals*

All Casualty Receiving Hospitals should receive the yellow warning, which should be relayed immediately to the administrator, and superintendent of nurses, and the chief engineer.

BLUE WARNING SIGNAL

1. *Mobile Medical Teams*

(*a*) Teams composed of resident personnel of hospitals prepare for action by assembling, with equipment, at a designated point in the hospital, and stand ready for orders from the Control Center.

(*b*) Teams composed of persons from the neighborhood of a hospital assemble at the hospital.

(*c*) Teams designated to assemble at Casualty Stations remote from a hospital report to the Casualty Station.

2. *Stretcher Teams*

Stretcher Teams on call assemble at their posts of duty at hospitals or Casualty Stations.

3. *Ambulance Teams.* (Driver and Attendant)

(*a*) Teams composed of persons on duty at a hospital or depot at which the ambulance is parked prepare their vehicles and equipment for action.

(*b*) Teams composed of persons residing in the neighborhood of hospitals or ambulance depots assemble at the hospital or depot at which they are on call.

4. *Hospital Personnel*

The following will report to the hospitals to which assigned: physicians on shock, surgical, triage, fracture, or other emergency teams; anesthetists; nurses and Volunteer Nurses' Aides on call at the time for emergency duty; hospital protection personnel such as Wardens, Fire Guards, Messengers, and essential maintenance personnel.

In preparing hospitals for action, every effort should be made to reduce to a minimum the movement through streets. Hospital administrators and Chiefs of Staff should,

therefore, determine their minimal requirements and recommend emergency personnel for membership in the U. S. Citizens Defense Corps or the Civilian Defense Auxiliary Group (see Operations Letter No. 37 and Supplement No. 1 thereto). The Chief of Emergency Medical Service should arrange for the appointment, training, and proper identification of such emergency personnel.

RED WARNING SIGNAL

Members of the Emergency Medical Service stand by at their posts throughout the red warning period until dispatched to incidents or Casualty Stations on orders from the Control Center. The physician in charge of a Mobile Medical Team at a hospital or Casualty Station may send forward a Stretcher Team or other personnel to near-by incidents on his own initiative.

OMISSION OF YELLOW OR FIRST BLUE WARNING

The sudden or rapid approach of enemy planes may prevent the giving of either the yellow or blue warning, or both. In the event that a red warning is given without preliminary warnings, Emergency Medical Service personnel will immediately take the action normally taken on the yellow and blue warnings.

BLUE WARNING SIGNAL FOLLOWING RED

Emergency Medical Service personnel remain at assigned posts or at posts to which they have been dispatched until relieved by the Chief of Emergency Medical Service.

ALL CLEAR

Emergency Medical Service personnel remain at their posts of duty until relieved by the Chief of Emergency Medical Service.

NOTE.—When practice drills are planned in advance, the Chief of Emergency Medical Service may excuse all or part of the physicians who have taken part in previous drills from participating in the exercise. Unless specifically excused in advance, physicians and other personnel of the Emergency Medical Service should mobilize on every alert in accordance with the above outline.

Medical Journals—For Colleagues in Military Service

In former issues, editorial comment was made on a plan to forward medical journals to the Hospital Stations of Army, Navy, and Air Force camps now located in California.

This work is being carried on by the California Medical Association—through its Committee on Postgraduate Activities—in coöperation with the medical libraries of the University of California, Stanford, and the Los Angeles County Medical Association.

The addresses of the three libraries follow:

University of California Medical Library, The Medical Center, Third and Parnassus, San Francisco, California.

Lane Medical Library, Clay and Webster Streets, San Francisco, California.

Los Angeles County Medical Library Association, 634 South Westlake, Los Angeles, California.

If more convenient, you can send journals via "Railway Express Agency," collect, to: California Medical Association Postgraduate Committee, Room 2008, Four Fifty Sutter, San Francisco, California. Railway Express Agency addresses: In San Francisco, at 635 Folsom (EX 3100); in Los Angeles, at 357 Aliso (MU 0261). The "Railway Express Agency" will call for packages and will collect costs from the California Medical Association. The Postgraduate Committee will forward to camps.

Eye Deficiencies Chief Cause for Draft Ban

Eye defects were the chief cause for rejection of 18 and 19-year-old selective service registrants by the Army in the three months' period from last December to February.

In this age class, 23.8 per cent of all white youths summoned for induction were rejected, and 45.5 per cent of all negroes called were turned down.

Only part of the rejections were for physical reasons. Other reasons included previous enlistment, enrollment in a specialized course of training and employment in vital industry and agriculture.

Among white youths the principal causes for rejection, after eye defects, were listed as mental disease, muscle and bone defects, heart and blood vessel defects, ear defects, hernia, neurological defects, educational deficiency, underweight, and mental deficiency.

Among negroes the nine leading causes of rejection in the same age group were social disease, heart and blood defects, mental disease, muscle and bone defects, hernia, eye defects, neurologic defects, mental deficiency, and tuberculosis. Half of the rejections of negro youths resulted from educational deficiency and social disease.

Association of Military Surgeons of the United States

Rear Admiral Ross T. McIntire, Surgeon-General of the United States Navy, and personal physician to President Roosevelt, will serve as honorary chairman for the fifty-first annual convention of the Association of Military Surgeons of the United States to be held in Philadelphia on October 21, 22, and 23.

A symposium on war medicine, which will chart the progress and the recent advances made in the care and hospitalization of men in the armed forces will highlight the three-day meeting in the Bellevue Stratford Hotel.

Officials of the convention expect an attendance of more than two thousand doctors now attached to the fighting forces, many of whom will return from the battle fronts and from every section of the country where men are stationed, to hear the lectures and to take part in the panels and discussions that will mark the conference.

The surgeons-general of the United States, ranking military officers, and national, state, and municipal officials are expected to be present at the convention.

Maternity-Pediatric Plan of Federal Children's Bureau

(Additional items—Continued from pages 79-88, CALIFORNIA AND WESTERN MEDICINE, for July (Items I to XVIII), and September, pages 178-182 (Items XIX to XXIII).)

ITEM XXIV: MATERNITY-PEDIATRIC

United States Child Care Fund Increased

Washington, Sept. 22.—The House Appropriations Committee, estimating there will be 645,000 pregnancies among wives of enlisted service men during fiscal 1944, today recommended $18,620,000 deficiency appropriation for the Government's maternity and child-care program.

When the program was first started, the Committee said, it was estimated that the total number of pregnancies would be 300,000 and that 25 per cent of the wives would apply for Government care.

Later experience showed, however, that the number will be more than doubled and that 50 per cent of the wives are seeking aid, the Committee added.

Before the summer recess, Congress appropriated $6,600,000 for the maternity and child-care program in the belief then that this amount would carry it for the entire twelve months.—San Francisco *News*, September 22.

* * *

House Passes Baby Fund

Washington, Sept. 22 (AP).—Without a dissenting vote, the House passed and sent to the Senate today a bill appropriating $18,620,000 for assistance to service men's wives who become mothers.

The appropriation supplements $5,600,000 provided for the same purpose since last March, but already spent at an average cost of $84.50 per case.

The House voted down, 115 to 8, a proposal that the aid be given in cash to the mothers, and ordered instead that it be used to pay medical, nursing, and hospital bills direct.

ITEM XXV: MATERNITY-PEDIATRIC

A Bad Precedent in Dangerous Times

The future of safe maternity care for the mothers and babies of America hangs in the balance this summer. It hangs there because an attack has been made on the high standards which have been developed by the medical profession, the health departments, the Maternity Center Association, the Federal Children's Bureau, and civic-minded citizens during the past quarter of a century. We have been very proud in recent years of the rapidly declining maternal mortality. In city after city and state after state, almost miraculous declines have occurred in the number of deaths and injuries to mothers and babies before, during and after birth.

What has caused these declines? All who are familiar with the situation know that the increasingly high standards of obstetric care are largely responsible. Doctors and nurses have taken refresher courses. The standards of teaching in medical and nursing schools have been improved. New advances have been made in chemotherapy; in the control of infection, toxemias, hemorrhage; in pelvimetry to avoid needless difficult and dangerous labor; in surgery to make cesarean sections safer and in the safe relief of all unnecessary pain. The great scientific advances in the care of premature babies have been made available in thousands of communities.

Wherever these new high standards have been put into practice, maternal and infant deaths have drastically fallen. In the States and among the groups of our population where they have not been put into practice, needless death and injury still take a ghastly toll of life and health among mothers and babies.

This is an important time in our nation's history, for all forward-thinking professional people and civic-minded citizens are convinced that the benefits of these new scientific advances made by the medical profession must be made available to every mother and her baby, regardless of her ability to pay. Never in our nation's history have high standards mattered more, for precedents are being set that may have their effect in the legal framework of our nation for years to come.

At this critical moment, when high standards are being unanimously accepted and states, where standards have been low are striving to raise them quickly, Congress, over vigorous protest, passed an innocuous-appearing amendment to the appropriation for the Children's Bureau, relating to the provision of care for the wives and babies of service men. In legal language this amendment says: *"That no part of any appropriation contained in this title shall be used to promulgate or carry out any instruction, order or regulation relating to the care of obstetrical cases which discriminates between persons licensed under state law to practice obstetrics: Provided further, That the foregoing proviso shall not be so construed as to prevent any patient from having the services of any practitioner of her own choice, paid for out of this fund, so long as state laws are complied with."*

The Standards Are Revoked

The immediate result of this amendment was to require the Chief of the Children's Bureau to send the following memorandum to the various state health departments throughout the country: *"All instructions previously issued by the Children's Bureau requiring such minimum qualifications for physicians participating in the maternal and child health and emergency maternity and infant care program in so far as such instructions relate to the care of obstetrical cases are hereby revoked. In approving state plans in the future, the Children's Bureau will not pass upon the standards set forth in such plans for practitioners performing obstetrical services thereunder. The Children's Bureau, in its consideration of such standards, will pass solely upon the question whether state laws have been complied with."*

This means that the Children's Bureau is deprived of the right to suggest standards of obstetric practice for the expenditure of this money. But more than that, in human terms, it may mean the life and the health of many a mother and her baby. Under the terms of this amendment, the wife of a service man, who is expecting a baby, may, in her ignorance, select a cultist who is licensed to practice obstetrics in his State and who, under the law, may be paid from federal funds. He may be unable to use medications, to prescribe drugs, to do even minor surgery or to be admitted to the local municipal or voluntary hospital. It is fortunate that many mothers have been educated to select care wisely, by the continuous and vigorous efforts of many organizations, including the federal Children's Bureau, with its famous and popular booklets, "Prenatal Care" and "Infant Care."

Congressman Walter H. Judd of Minnesota, voicing strong opposition to the enactment of this amendment, declared: "The argument is made that, after all, this is a matter for the states to decide; and if certain states license individuals with lesser training to practice obstetrics, who are we to say who shall practice obstetrics within their jurisdiction? It is an argument with which I concur wholeheartedly, except under two conditions: first, when the standards in the states are reasonably uniform. Such is not the case in this instance. The chief objection is not to those states which have laws requiring the passage of examinations in the basic sciences and require that men or women, to be permitted to practice obstetrics in the state, shall serve proper internships and demonstrate that they possess high-grade qualifications in the handling of abnormal as well as normal obstetrical cases.

"The great danger we see in this provision comes from those states which have low standards, where almost any good-hearted mammy who believes that she is called of God to take care of women in childbirth is licensed to go out and do so. We feel that it is most dangerous for a provision like this to be slipped through without careful consideration or debate, and without recognizing what it does to the high standards which have been worked out very carefully by the medical profession all during these years.

"Objection can be raised that so many doctors are now in the service, that it is not possible to get obstetrical care unless in some states men and women with lower standards of training are used. It is true that in most obstetrical cases if the attendant merely exercises masterful inactivity and knows enough not to intervene, nature will take care of itself. But the test comes when things do not proceed normally. When to intervene, what needs to be done, how to do it—in no emergency of medicine or surgery is better judgment and more skill needed.

"For example, the individual who is able to handle normal obstetrics satisfactorily meets a situation where a cesarean section is necessary to save the woman's and the child's life. He is not qualified or licensed to do major surgery. It is natural for him to try, as long as he can, to use the method that he or she is accustomed to. He is likely not to recognize in time his own limitations. He does not like to confess his own inadequacy and call in a doctor who is adequately trained. He may delay until the woman's life cannot be saved nor the child's. All these years we have worked to lower the infant and maternal mortality

throughout the country and with spectacular results. Here we are doing a thing which is bound to increase the mortality rate in many States."

The Foot in the Door?

The congressmen who advocated the amendment made it quite clear that it applied only to obstetric care, not to the care of crippled children or to the other phases of the program of the Children's Bureau, but it is poor logic to require under law that crippled children must be cared for by practitioners with the highest qualifications and experience, but to permit babies to be delivered and cared for by these so-called cultists. A large percentage of crippling occurs at birth, and this is due chiefly to poor medical care. There just is not any sense to it unless this is only a first step to let down the bars for all kinds of medical care. It may be the foot in the door. It is a bad precedent and one which must be fought by all those who are interested in maintaining high standards of care throughout this land.

The amendment tends to cause confusion rather than to simplify matters. Even on the floor of Congress there was sharp disagreement of opinion as to whether states permitting midwives and chiropractors to care for mothers actually licensed them or not. This clause does not differentiate between those who know their business and those who do not. Undoubtedly, some osteopaths, graduates of recognized schools, can and do provide safe obstetric care, but there are others called by the same name who are merely graduates of the old diploma mills and who have no experience and no training in this field.

This new amendment makes no discrimination between the good and the bad, the sheep, and the goats. It is not wise legislation nor sound social policy. We cannot permit the health and well-being, the strength and vigor of our next generation to be tampered with by the lobbyists of any pressure group in Washington, and no doubt this law is the result of clever and powerful manipulation. This is the time to nip bad precedents in the bud.—Mrs. Shepard Krech, President, Maternity Center Association, in *Briefs*, publication of the Maternity Center Association, 654 Madison Avenue, New York, 21.

ITEM XXVI: MATERNITY-PEDIATRIC

Best Medical Care for Service Men—Second-Rate Care for Their Wives and Babies: Statements by Members of Congress

The armed services insist on the best medical care for the men on the fighting fronts and in the training camps. They will not commission osteopaths, chiropractors, naturopaths, and their kith and kin, as medical officers. Dr. James C. Magee, former Surgeon-General of the Army declared, "The citizens of this country who give their sons to the military service have every right to expect that they will receive the highest type of medical attention when they are sick or wounded. In order to carry this out, it is imperative that only those physicians whose training has been based upon sound, scientific principles can be utilized in their care." This has been reiterated by his successor, Surgeon-General Kirk.

Certainly, the same high quality of care should be provided to the wives of these men, who are often facing hard times at home because their husbands are away. They will have to be mother and father to their baby, and they need all the strength and health that they can muster to do the job right.

Senator Robert LaFollette of Wisconsin made it quite clear where he stands on this matter: "I want no father of a child born while the father is overseas fighting for his country to point his finger at me and say, 'You are responsible for the death of my wife and child in my absence, because a man was permitted to minister to her at her time of need who was not properly equipped, who was not licensed to use drugs, who was not licensed to practice surgery.'

"Under the present law, the Children's Bureau has the right to set standards for persons who are eligible to be paid out of federal monies so far as this program is concerned. Personally, I believe that the dearth of physicians and surgeons has been seized upon as a means of striking down the standards which have been established. I am satisfied that those who are administering the program are just as determined as is anyone else to see that women are afforded proper service, and they will see that they get it. I don't think there is a scintilla of evidence before either of the committees to show that any person eligible for obstetrical care under this program has been denied proper care because of these standards. There has been considerable general talk about the scarcity of physicians, which everyone knows is true; but, so far as I know, not one scintilla or shred of evidence has been presented to show that because of the high standards required any service has been denied to any woman eligible for it.

"I say that to yield on this matter is a step backward in modern practice of obstetrics, and it is unfair to the service men, who are preparing to give their lives for their country, if necessary, that their wives, who are pregnant and who are to be delivered in their absence, shall not have the benefit of the finest standards and the finest care that money can procure.

"Yet, in this false application of the so-called doctrine of states' rights, such a situation will be created that the Congress will have done that very thing. So far as I am concerned, I want no part of it."

Representative I. D. Fenton of Pennsylvania, on the floor of the House commented: "The action taken here today will permit those people who are not recognized in regular medicine to deliver babies of the wives of our soldiers. Our military authorities refuse to grant these same people the right to receive commissions in the Army to administer to the boys while they are in service. Now they are going to permit them to go out in the general practice of medicine and to try to deliver the babies of the wives of these boys who are in the Army. I think we are taking a step backward."

Thus, we find that this harmless-appearing amendment enacted in the hustle and bustle of the days before the Congressional summer recess, can and will bring needless suffering and death to the wives and children of the men now fighting our battles in Sicily, Europe, Asia, Africa, and the islands of the South Seas.—From *Briefs*, publication of the Maternity Center Association, 654 Madison Avenue, New York, 21.

* * *

"APPROPRIATION BILL NO PLACE FOR SUCH AN AMENDMENT"—CHANDLER

"In my opinion, the provision in question would do irreparable harm to the services performed by the Children's Bureau, and their fine work in saving the lives of little children. It is my definite conviction that it will cause very great harm to child welfare work in the states, and to the state health bureaus, and that same bill should be passed forthwith to clarify the situation. It should be handled carefully, after public hearings, and with a clear understanding of the problem. An appropriation bill is not the place for such a provision."—Senator Albert B. Chandler of Kentucky.

* * *

"A HARMFUL AMENDMENT"—LODGE

Said Senator Henry Cabot Lodge, Jr., of Massachusetts, on the floor of the Senate: "The effect of the amendment is to make it possible for child-bearing women who are treated under the provisions of the Act to have the services

not only of obstetricians and of osteopaths, but of chiropractors and midwives.

"I fully appreciate the place of these various practitioners in our scheme of things, and I am saying nothing whatsoever in criticism of them. In general, I will be found to be a believer in the rights of the states and opposed to trespassing on them; but I submit that in cases where federal funds are being employed, the Federal Government has a right to impose the precept or standard without being accused of violating the rights of the states.

"In this particular case the Children's Bureau desires to give the women who need care the very best possible care.

"There is no question here about denying to any woman the right to have any kind of medical care she wants with her own money, but when we are administering a federal program, with federal funds, I believe the same federal standard that is complied with in regard to medical care in every other branch of the federal service which concerns itself with medical care should be applied to the women of the nation, and to the wives of the soldiers. In my opinion, it would not be right to expose them to a degree of medical care which is inferior to that which is received by their husbands.

"I am very sorry the amendment was agreed to . . . I merely want the Record to show that I believe this is a harmful amendment in the form in which it is now written."

* * *

AMENDMENT HINDERS STATE ADMINISTRATION SAYS FORMER STATE HEALTH OFFICER—CONGRESSMAN MILLER

Dr. A. I. Miller, Congressman from Nebraska and former State Health Director, put it this way: "I want to say to the House that this amendment, if it is left in the bill, will hinder the administration of the funds in a manner which is unwise.

"There are many States in which individuals are permitted to take care of obstetrical cases, but where they are not permitted to perform certain acts, like the administration of hypodermics or the repair of lacerations. It is a question of deciding if this House wants quantity of care or quality of care for the wives of our soldiers. In the practice of surgery and in the practice of obstetrics, many new things have been discovered in the last quarter of a century. There are many medicines that are being used today by men who have qualified to take care of women who are having babies that were not used a few years ago.

"If you adopt this amendment, it will make it impossible for the Children's Bureau or the health directors in many of the states to use the funds and give these women who are going to have babies the type and quality of care you would want your daughter or your neighbor's daughter to have. . . . You are, in effect, keeping future mothers from getting the quality of care they should have."

ITEM XXVII: MATERNITY-PEDIATRIC

Malpractice Liability: Re Services to Wives of Enlisted Men

(COPY)

San Francisco, September 15, 1943.

Dear Doctor:

This will acknowledge receipt of your letter of September 11, 1943, relative to malpractice liability of physicians rendering medical services to wives of enlisted men in the armed forces during pregnancy. You advise in your letter that such services are rendered under a program administered by the State Board of Health under authorization from the Federal Government.

In my opinion, the status of a physician rendering services under this program and being paid by the State of California is similar to physicians who render services, gratuitous or compensated, in county hospitals and similar institutions. Generally speaking, physicians who render professional services on behalf of a state, county, or municipality are considered to be public officers and the rules of law applicable to public officers in general are applied to them in determining their rights and liabilities.

The rule is stated in *21 California Jurisprudence* at page 908:

"It is elemental that a public officer is liable to respond in damages to one specially injured by his neglect or refusal to perform or by his negligent performance of an official ministerial duty to the extent of such special injury, regardless of intentions, whether good or bad."

The courts have uniformly held that neither the state nor the county is liable for the malpractice of a physician or surgeon employed by the state or county, but that *the physician himself is liable* in every respect in the same manner as a physician who is engaged in private practice and renders professional services to his own private patients. It has long been established law that the fact that a physician or surgeon who renders his services gratuitously does not absolve him from the duty to use reasonable and ordinary care, skill, and diligence. There are many instances where physicians or surgeons have been charged with liability for malpractice on account of services donated in the county hospitals and similar institutions.

Accordingly, it is my opinion that, in rendering professional services under the federal program referred to in your letter, you would be subject to liability for malpractice to the same extent and under the same conditions as in the case of your private patients.

In cases such as this the courts base their decision upon the premise that the fact that a physician is rendering his services gratuitously or at a reduced fee does not absolve him from the duty to use reasonable care.

Very truly yours,

(Signed) HARTLEY F. PEART

ITEM XXVIII: MATERNITY-PEDIATRIC

Soldiers' Babies

Local physicians, like medical men all over the state and nation, are "in a spot" regarding the federal program to provide care for wives of noncommissioned service men when they are having their babies. The doctors are in entire accord with the principle involved, for they recognize that these young men are ill-paid, that the coming of a baby always entails considerable expense, and that in thousands of cases the young mother has to go through her ordeal with her husband thousands of miles away. In such instances a little federal money would be a godsend.

The physicians recognize these things, yet, as was stated at a meeting of the Santa Clara County Medical Society this week, they are opposed to having the Government set the fees for their services, which is what happens as the system is now set up.

Socialized medicine is the fear and bugaboo of nearly all American physicians. They know that certain elements in the Administration favor it strongly. They have seen how badly it has worked in some countries in Europe. They feel, in all honesty and sincerity, that the public is less likely to get competent and conscientious care under a system of socialized medicine.

Most physicians recognize that the present system here in America is not perfect and that the very rich and very poor tend to get good care, while the vast middle class find illness a pretty hard financial burden. Most medical organizations are trying to do something about this situation. They are afraid, however, of wholesale control of medicine by the Government, just as a lot of other people in other lines are afraid of wholesale federal control.

In regard to this problem of providing Government aid for wives and babies of service men, the problem of the physicians is to make it plain that they endorse the principle, but dislike the present method. Instead of having the Government set fees and charges, they think the money should be paid to the mother, who would thereupon apply it to hospital and medical costs, as she desires.

So far as the mother and baby are concerned, the result would be the same. So far as the American medical profession is concerned, the revised plan would preserve one more angle of their business from federal control.—Editorial in San Jose *News*, September 18.

ITEM XXIX: MATERNITY-PEDIATRIC

Federal Children's Bureau Plan: Resolutions of Component County Medical Societies in California (Santa Clara, Sacramento, Solano, Contra Costa and Yolo)

RESOLUTION ADOPTED BY SANTA CLARA COUNTY MEDICAL SOCIETY

September 9, 1943

Philip K. Gilman, M. D.
Chairman of the Council

Re: Plan of Federal Children's Bureau to Provide Obstetric and Pediatric Care for Wives and Infants of Enlisted Men.

Dear Doctor Gilman:

At the meeting of the Council of the Santa Clara County Medical Society held September 8, 1943, the above subject was thoroughly discussed.

The Council was unanimous in approving the stand taken by the California Medical Association regarding this matter.

(Signed) JOHN HUNT SHEPHARD, M. D.,
Secretary, Santa Clara County Medical Society.

* * *

RESOLUTION ADOPTED BY SACRAMENTO SOCIETY FOR MEDICAL IMPROVEMENT

WHEREAS, At a special meeting of the Board of Directors of the Sacramento Society for Medical Improvement held on August 18, 1943, the following resolution was passed:

WHEREAS, The Board of Directors of the Sacramento Society for Medical Improvement approves in principle the federal Children's Bureau plan for maternity and infant care for wives and children of certain groups of enlisted men; and

WHEREAS, They are strenuously opposed to the procedure proposed in this plan which forces a physician to contract with the Federal Government for both medical services and hospitalization at certain fixed fees, and feel that an amplification of the above method will eventually lead to the socialization of medicine with a consequent lowering of the standards of medical care; therefore, be it

Resolved, That the Council of the California Medical Association be requested to reconsider this entire plan and provide state wide leadership in order that a cash allotment to the patient be substituted for the present method; be it further

Resolved, That failure to obtain active progress in the removal of the objectionable features of this plan within ninety days will lead to the withdrawal of coöperation by the Sacramento Society for Medical Improvement.

* * *

RESOLUTION ADOPTED BY THE SOLANO COUNTY MEDICAL SOCIETY

WHEREAS, The resolution of the Board of Directors of the Sacramento Society for Medical Improvement was on September 14, 1943, presented to the membership of the Solano County Medical Society at a regular meeting of that society; and

WHEREAS, The members of the Solano County Medical Society heartily approve of the above resolution; therefore, be it

Resolved, That the Solano County Medical Society unanimously endorse the aforesaid action of the Board of Directors of the Sacramento Society for Medical Improvement; and be it further

Resolved, That failure to obtain active progress in the removal of the objectionable features of this plan within ninety days will lead to the withdrawal of coöperation by the Solano County Medical Society.

* * *

RESOLUTION ADOPTED BY CONTRA COSTA COUNTY MEDICAL SOCIETY

WHEREAS, The Contra Costa County Medical Society approves in principle the federal Children's Bureau plan for maternity and infant care for wives and children of certain groups of enlisted men; and

WHEREAS, They are strenuously opposed to the procedure proposed in this plan which forces a physician to contract with the Federal Government for both medical services and hospitalization at certain fixed fees, and feel that an amplification of the above method will eventually lead to the socialization of medicine with a consequent lowering of the standards of medical care; therefore, be it

Resolved, That the Council of the California Medical Association be requested to reconsider this entire plan and provide state-wide leadership in order that a cash allotment to the patient be substituted for the present method; and be it, therefore,

Resolved, That failure to obtain active progress in the removal of the objectionable features of this plan within ninety days will lead to the withdrawal of coöperation by the Contra Costa County Medical Society.

* * *

RESOLUTION ADOPTED BY YOLO COUNTY MEDICAL SOCIETY

WHEREAS, The Yolo County Medical Society approves in principle the federal Children's Bureau plan for maternity and infant care to the wives and children of certain groups of enlisted men; and

WHEREAS, They are strenuously opposed to the procedure proposed in this plan which forces the physician to contract with the Federal Government for both medical services and hospitalization at certain fixed fees and the enormous amount of paper work and potential delay in payments that will be demanded; be it

Resolved, That the Council of the California Medical Association be requested to take a definite stand as regards this entire plan and provide state-wide leadership in order that a cash allotment to the patient be substituted for the present method.

ITEM XXX: MATERNITY-PEDIATRIC

Maternity and Infant Care by United States To Be Resumed in California

The Government will continue to take care of emergency maternity and infant care cases of wives of service men, Dr. Wilton L. Halverson, State Department of Health director, announced today.

This service, suspended on September 15 because of lack of funds, will be resumed here and in thirty-four other counties, Doctor Halverson said. His department has been assured of an immediate grant of $461,606 to pay for the individual care of individuals whose applications have been approved and to provide care through this month.

"The United States Children's Bureau has been notified that, due to the large number of service men's wives living

in California and the high cost of medical care here, an estimated four million dollars will be required to carry the program in this state through the 1943-44 fiscal year," declared Doctor Halverson.

(A new congressional appropriation of $18,600,000 for this purpose has been set up.)

Any woman, irrespective of her legal residence, whose husband is an enlisted man in the Fourth, Fifth, Sixth, or Seventh grades in the Army, Navy, Marine Corps or Coast Guard, is eligible under the program for medical and hospital maternity care without cost.

Care is provided throughout pregnancy and for six weeks after delivery as well as at confinement. Any infant under a year whose father is a service man in these grades is also entitled to care for serious illness.

"Spread of the program to the rest of the counties is awaiting completion of satisfactory arrangements with local health departments, physicians, and hospitals," Doctor Halverson concluded. "Payment for care is made on a cost basis by health departments administering the program."—San Francisco *News*, October 2.

COMMITTEE ON ASSOCIATED SOCIETIES AND TECHNICAL GROUPS

War-Time Nursing

(COPY)

WAR MANPOWER COMMISSION

Washington 25, D. C.,
September 1, 1943.

California and Western Medicine,
Addressed.

The attached statement has been issued by the Directing Board of War Manpower Commission's Procurement and Assignment Service for physicians, dentists, veterinarians, sanitary engineers, and nurses.

The Directing Board would appreciate your coöperation in calling to the attention of members of your profession the important problems discussed in the statement.

* * *

WARTIME NURSING IS DIFFERENT

It is utterly impossible to provide the necessary volume of wartime nursing service on a peacetime basis. Places where nursing is going on as usual must share with others. Individual nurses who have not made adjustments to wartime needs for their service should understand the necessity for their participation.

The National Nursing Council has pointed out that the value of any national plan must be judged by its usefulness at the local level, *i. e.*, where nurses live and work—in the country, in the villages, towns, and cities of the nation.

Wartime nursing is different. That inescapable fact must be generally accepted by nurses, by physicians, and by hospital administrators. Energy and motion now spent in resistance to change must be released for the attack on war-created needs.

Nurses have wrought many changes, but not enough, in the pattern of nursing service since Pearl Harbor. . . .

The principles of good nursing have not changed, but nurses are learning to concentrate on the essentials. . . .

A critical shortage of nurses exists. Here are the facts:

Over 36,000 nurses are now with the armed forces, and the Red Cross has accepted responsibility for the recruitment of an equal number by June 30, 1944. Our men are receiving skilled medical care of a high order, as shown by the high percentage of recovery from injury. Skilled nursing is an important factor in such care. Then, too, the very presence of nurses near the bases of military operations has repeatedly been described as a potent force in maintaining morale.

There has been an unprecedented increase in the use of civilian hospitals. Hospitals gave fourteen and a quarter million more days of care in 1942 than in the preceding year and the trend still is definitely upward. . . .

Nursing is essential to the nation's health. The National Nursing Inventories (of nursing resources) of 1941 and 1943, by the United States Public Health Service, offer a comparison of data for the two years. See Table 1.

The total number of nurses graduated in the two years is well in excess of the number withdrawn for military service; this fact is not apparent in the inventory. . . .

The relatively small decrease in the number of institutional nurses is much less significant than the increased use of hospitals in creating the serious shortage of nurses. The increased number of nurses in industrial nursing is, of course, not surprising. . . .

Through the War Manpower Commission, nursing will not only have the benefit of the experience of medicine in the procurement and assignment of physicians, but means will be found to interpret wartime nursing to physicians and their coöperation secured in effecting desirable wartime adjustments.

REFERENCES

Priorities for Nurses. National Nursing Council for War Service, 1790 Broadway, New York, N. Y., May, 1943. Revised edition.

Distribution of Nursing Service During War. National Nursing Council for War Service, 1790 Broadway, New York, N. Y., 1942.

Volunteers in Health. Medical Care, and Nursing. U. S. Office of Civilian Defense, Washington, D. C.

TABLE 1.—*National Nursing Inventories*

	1941	*1943*
Total returns	289,286	259,174
Active		
Institutional	81,708	77,704
Public Health	17,766	18,900
Industrial	5,512	11,220
Private duty	46,793	44,299
Other	21,276	18,476
Inactive, but available for nursing	25,252	38,746 (of these 23,576 are married and under 40)
Inactive, not available	90,979	49,829
In Nurse Corps of Army and Navy	6,371	over 36,000 (precise data not available)

COMMITTEE ON POSTGRADUATE ACTIVITIES†

CALIFORNIA HEART ASSOCIATION

Meetings to Be Held in San Francisco, Los Angeles, and San Diego

Dr. Tinsley R. Harrison, Professor of Medicine at the Bowman Gray School of Medicine, Wake Forest College, Winston-Salem, North Carolina, will be the guest speaker at the symposia on heart disease to be held under the auspices of the California Heart Association. Doctor Harrison is one of the outstanding internists in the United States. His work on the mechanism of the circulation,

†Requests concerning clinical conferences, guest speakers, and other information, should be sent to the California Medical Association headquarters office, 450 Sutter, San Francisco, in care of the Association Secretary, who is secretary ex officio of the Committee on Postgraduate Activities.

The Place of the Radiologist in the Diagnosis and Treatment of Heart Disease, Wilbur Bailey, M. D., Los Angeles.

One Thousand Draft Rejections for Cardiovascular Conditions, William J. Kerr, M. D., Professor of Medicine, University of California Medical School, San Francisco.

The Differential Diagnosis of Palpitation, Tinsley R. Harrison, M. D., Winston-Salem.

FRIDAY, NOVEMBER 12

2 to 5 p.m.

Headquarters of the Los Angeles County Medical Association, 1925 Wilshire Boulevard

Nutritional Considerations in Heart Disease, Howard F. West, M. D., Los Angeles.

The Treatment of Cardiovascular Syphilis, C. Russell Anderson, M. D., Los Angeles.

The Patient with Diabetes and Heart Disease, Kendrick Smith, M. D., Los Angeles.

The Need for Conservatism in the Treatment of Acute Coronary Occlusion, J. Philip Sampson, M. D., Santa Monica.

A Clinical-Pathological Conference: Two Cases, Tinsley R. Harrison, M. D., Winston-Salem, and Alvin G. Foord, M. D., Pasadena.

Business Meeting. Election of Officers.

* * *

A fee of $10 will be charged. This includes admission to the symposium, annual dinner, membership in the Los Angeles and California Heart Associations, and annual subscription to "Modern Concepts of Cardiovascular Disease." Physicians in military service, interns, and residents will be admitted without charge, but a charge of $4 will be made for the dinner. The charge for guests at the dinner is $4. Admission to the symposium and the dinner will be by ticket. The Association regrets that it cannot accept requests for dinner reservations later than Monday, November 8. Tickets will be held at the registration desk, where they will be delivered to those whose applications and remittances have been received on or before November 8. Applications should be mailed to Dr. William Paul Thompson, Los Angeles Heart Association, 122 East Seventh Street, Los Angeles, 14.

COMMITTEE ON PUBLIC POLICY AND LEGISLATION

Wagner-Murray-Dingell Bill (S. 1161) and United States Public Health Service

(Surgeon-General Parran's Letter Thereon)

(COPY)

BETHESDA (14) STATION

July 17, 1943

Mr. Kenneth C. Crain:
V. P.-Eastern Editor
"Hospital Management"
330 West Forty-Second Street
New York, 18, N. Y.

Dear Mr. Crain:

This will acknowledge your letter of June 28 in which you ask for information about the plans of the Public Health Service for a medical care and hospitalization program to be developed along the lines proposed in the Wagner-Murray-Dingell Bill.

At the time Senator Wagner introduced the bill he stated the legislation was sponsored by the American Federation of Labor. Whatever its origin, it is not an Administration bill, and I did not see it before it was introduced. The Public Health Service has as yet developed no plans for a comprehensive medical care or hospitalization program. Indeed, implementation of the provisions of the bill at this time would appear to be difficult, if not impossible, in the face of existing and increasing shortages of medical personnel and of materials for the construction of additional health facilities.

As you can readily appreciate, my immediate concern is with urgent health needs in communities affected by the war either directly or indirectly. Considerable difficulty has been encountered in constructing even the few hospitals and hospital additions which are absolutely essential to serve the increased population in war industry and extra cantonment areas. The withdrawal of physicians from communities which never did have adequate medical services has created another problem, as has the shortage of nurses.

Thus, our efforts for the present must be directed mainly toward emergency activities dictated by the war. Yet we cannot shut our eyes to the long-time health needs of the country nor can we wait until the war is over before considering ways in which the needs should be met. Proposals for national health programs are being advanced in several countries, notably Great Britain, Canada, Australia, and New Zealand. In this country, too, there is a revival of interest in some form of concerted action to bring out a more equitable distribution of health services and facilities after the war.

If and when a new health program is developed in this country, I think it will come as a result of free and open discussion of principles, objectives, and methods of implementation. The subject is highly controversial, as you have indicated, yet I believe we could avoid much of the bitterness that has delayed progress in other countries and has set at cross purposes those who should be working for the common good.

Personally, I have no cut-and-dried plans about the pattern to be followed in developing a comprehensive program—assuming one to be feasible financially and administratively in the near future. I think we would all agree that health services should be available to everyone and that the Government has a responsibility for the health of the people. I believe, too, that much greater emphasis should be placed on preventive medicine in community health activities and in the care of individuals and that present artificial barriers between prevention and cure should be broken down, not strengthened. At this time I do not see how we can go much beyond these general statements, for further discussion will be necessary before any commitments can be made. In approaching this whole broad problem there will be need for mutual trust and cooperation, freely given by public and private agencies alike, by professional and lay organizations, and by all groups and persons sincerely devoted to the advancement of health.

I greatly appreciate the interest you have shown in the work of the United States Public Health Service.

Sincerely yours,

THOMAS A. PARRAN,
Surgeon-General.

Chester Rowell: Bugaboo Arguments on Health Insurance*

(COPY)

Somebody sends a reprint of a letter from a letter from a Chicago correspondent to the *Christian Science Monitor* quoting medical, not Christian Science, objections to an alleged "Wagner-Murray" bill said to be before Congress which, under the guise of sickness insurance, has for its real purpose the destruction of "free economy" and the "complete bureaucratic domination of the American people," and the reduction of the doctors to "abject slavery." Incidentally, "the cost of the individual family head would average $120 a year," or a total to the United States of over three billions.

If the arguments were Christian Science ones, made by the church or by the *Monitor* on its behalf, they would be entitled to the most serious consideration. Many of those who prefer to be treated by Christian Science prac-

* For editorial comment, see page 208.

given to the medical profession in his book, "The Failure of the Circulation," is a notable contribution to cardiology.

The meetings will be held on these dates:

San Francisco—November 4, 5, and 6.
Los Angeles—November 11 and 12.
San Diego—November 9 (dinner meeting only).

* * *

San Francisco Heart Committee

THURSDAY MORNING, NOVEMBER 4, 1943

9:30 a.m., to 12 noon

Stanford University Medical School, Stanford Hospital
Lane Hall, Sacramento Street, near Webster

David R. Rytand, M. D., Presiding

Considerations of Anemia with Heart Disease, Robert S. Evans, M. D.
Coexistence of Rheumatic Heart Disease and Glomerulonephritis, Ann Purdy, M. D.
Hypercholesterolemia in Coronary Artery Disease, J. K. Lewis, M. D.
The Abuse of Rest in the Treatment of Cardiovascular Disease, Tinsley R. Harrison, M. D.

THURSDAY AFTERNOON, NOVEMBER 4, 1943

1:30 p.m. to 4:30 p.m.

Stanford University Medical School, Stanford Hospital
Lane Hall, Sacramento Street, near Webster

Clinical-Pathological Conference, Tinsley R. Harrison, M. D., and Alvin J. Cox, Jr., M. D.
Diagnostic Value of X-Ray in Certain Types of Heart Disease, James B. Irwin, M. D.
Masked Hyperthyroidism with Heart Disease, Lester S. Lipsitch, M. D.
The Relationship of Hypertension to Arteriosclerotic Heart Disease, Arthur Selzer, M. D.
The Heart in Obesity, David A. Rytand, M. D.

FRIDAY MORNING, NOVEMBER 5, 1943

9 a.m. to 12 noon

University of California Hospital, Toland Hall
Third and Parnassus Avenues

Dr. Leslie Bennett, Presiding

9:00 a.m.—*Rheumatic Fever, 1943,* Lt. Comdr. Harold Rosenblum, M.C., U.S.N.R.
9:30 a.m.—*Aids to the Physician in the Convalescent Care of Rheumatic Fever Patients,* Miss Ethel Cohen.
9:45 a.m.—*A Restudy of One Thousand Men Rejected by Selective Service for Alleged Cardiovascular Disease,* Dr. William J. Kerr representing the Board, consisting of Doctors Edwin L. Bruck, Francis L. Chamberlain, Paul A. Gliebe, J. K. Lewis, E. R. Miller, J. Marion Read, David Rytand, John J. Sampson, Mayo H. Soley.
10:15 a.m.—*Recess.*
10:25 a.m.—*The Smithwick Splanchnicectomy for Essential Hypertension,* Dr. Howard C. Naffziger.
11:00 a.m.—*Gostro-Intestinal Disorders Simulating Angina Pectoris,* Dr. Tinsley Harrison.

FRIDAY AFTERNOON, NOVEMBER 5, 1943

University of California Hospital, Toland Hall
Third and Parnassus Avenues

A Symposium on Therapy, Dr. W. J. Kerr, Presiding
(To run concurrently with program below in Room 437)

1:30 p.m.—*The Management of the Patient with Cardiac Arrhythmia,* Dr. Francis Chamberlain.
2:20 p.m.—*The Management of the Patient with Congestive Failure,* Dr. Charles Noble.
3:10 p.m.—*The Management of the Patient with Coronary Artery Disease,* Dr. W. J. Kerr.
4:00 p.m.—*Some Common Errors in Interpretation of Electrocardiograms as Indicating Coronary Artery Disease,* Dr. Tinsley Harrison.

* * *

University of California, Room 437
Out-Patient Department

Dr. Leslie Bennett, Presiding

(To run concurrently with program above in Toland Hall)

1:30 p.m.—*The Management of the Patient with Hypertensive Heart Disease,* Dr. Leslie Bennett.
2:20 p.m.—*The Management of the Pregnant Woman with Heart Disease,* Dr. Ellen Brown.
3:10 p.m.—*The Management of the Patient with Luetic Heart Disease,* Dr. Paul Aggeler.

FRIDAY EVENING, NOVEMBER 5, 1943

8 p.m. to 10:15 p.m.

San Francisco County Medical Society
2180 Washington Street, at Laguna

Francis L. Chamberlain, M. D., Presiding

The Present Status of Research in Hypertension, Tinsley R. Harrison, M. D.
Round-Table Discussion of Questions Submitted by Registrants—Drs. Arthur L. Bloomfield, Francis L. Chamberlain, Tinsley R. Harrison, William J. Kerr, J. K. Lewis.
Election of Officers.
Beer and sandwiches.

SATURDAY MORNING, NOVEMBER 6, 1943

9 a.m. to 12 noon

San Francisco Hospital

Potrero Avenue and Twenty-Second Street
(Report at Main Entrance of Hospital)

Charles A. Noble, Jr., M. D., and J. Marion Read, M. D., Presiding

Clinical Demonstration of Various Types of Heart Disease.

Doctors will rotate through wards in small groups to facilitate discussion and examinations including electrocardiography and x-ray films.

Participants:

Stanford University—George De F. Barnett, Walter Beckh, Lovell Langstroth, J. K. Lewis, Lester S. Lipsitch, Arthur Selzer.

University of California—Henry Brainerd, LeRoy H. Briggs, Edwin S. Bruck, Jesse L. Carr, Don G. Gardner, Allen T. Hinman.

Thirteenth Annual Symposium of the Los Angeles Heart Association

Thursday, November 11, and Friday, November 12, 1943.

Guest Speaker: Tinsley R. Harrison, Professor of Medicine, The Bowman Gray School of Medicine, Wake Forest College, Winston-Salem, North Carolina.

Officers of the Association: Louis E. Martin, President; Wilbur A. Beckett, Vice-President; William Paul Thompson, Secretary-Treasurer.

THURSDAY, NOVEMBER 11

10 a.m. to 12 noon

Main Auditorium, First Floor, Los Angeles
County Hospital, 1200 North State Street

A Cardiac Clinic—Tinsley R. Harrison, M. D., Winston-Salem, North Carolina.

THURSDAY, NOVEMBER 11

2 to 5 p.m.

Headquarters of the Los Angeles County Medical Association, 1925 Wilshire Boulevard

The Practical Management of Patients with Hypertension, W. Gordon Garnett, M. D., Los Angeles.
The Diagnosis of Rheumatic Fever in Children, S. J. McClendon, M. D., San Diego.
On the Importance of Speaking One Heart Language, Wilbur A. Beckett, M. D., Los Angeles.
The Importance of Salt and Fluids in the Treatment of Congestive Heart Failure, Francis M. Smith, M. D., La Jolla.
Cardiovascular Disease in an Army General Hospital, Major Maurice Eliaser, Jr., M. C., Chief, Cardiovascular-Renal Section, Hoff General Hospital, Santa Barbara.
The Treatment of Cerebral Vascular Accidents, Leon G. Campbell, M. D., Pasadena.

THURSDAY, NOVEMBER 11

7 p.m.

Annual Dinner, California Club, 538 South Flower Street, Cocktails will be served at 6:30 p.m.
The Abuse of Rest in the Treatment of Cardiovascular Disease, Tinsley R. Harrison, M. D., Winston-Salem.

FRIDAY, NOVEMBER 12

9:30 a.m. to 12 noon

Headquarters of the Los Angeles County Medical Association, 1925 Wilshire Boulevard

The Critical Diagnosis of Angina Pectoris, Donald E. Griggs, M. D., Los Angeles.
The Importance of the Electrocardiogram in Coronary Artery Disease, Edward C. Rosenow, Jr., M. D., Pasadena.

casting brilliant light without shadows. Other provisions have been made for emergency lighting in the event the regular lighting system should fail. One of the outstanding features of this hospital is the elaborate communications system which allows each patient to talk directly to the nurse at her desk, and the nurse to reply to the patient. This saves many steps for the nurses, who by the old system had to first come to the patient's room to answer requests. The hospital itself was built and equipped by the Kaiser Company, but is operated by Dr. Sydney Garfield under a plan similar to the shipyard hospitals in Oakland and Vancouver, which Henry J. Kaiser built at these projects. . . .

Employees and their families may obtain services for a very nominal weekly charge under the hospital service plan of the Southern Permanente hospital. At the present time this service is extended only to the employees of Kaiser Company, Inc., and members of their immediate family. However, in the event there are additional facilities in the hospital, nonemployees of the Company may obtain treatment at regular hospital charges similar to those of neighboring hospitals. — Pomona *Progress-Bulletin*, September 13.

Kaiser to Build East Bay Hospital

Washington, Sept. 15 (AP).—Henry J. Kaiser, West Coast industrialist, said today a new $1,200,000 hospital addition would be built in Oakland, California, with Federal Works Agency funds, for the prepaid care of shipyard workers' families and the public.

Health service will be rendered as in other Kaiser hospitals and clinics, on the basis of a small regular payment by Kaiser workers.

Kaiser said, in an interview, that his industries already had seven hospitals for Kaiser workers on the Pacific Coast who regularly contribute seven cents a day to the hospital funds on a voluntary basis, but that facilities are limited for the care of families.

"I have been arguing that all industry should do this," Kaiser said. "Maybe it should be made compulsory.

"I believe that we have got to take care of both the worker and his family to get production. If a man's family is sick, he isn't productive because he's worried and he's got to take time off."—San Francisco *Call-Bulletin*, September 15.

Pleasanton Navy Hospital to Open

The Navy announced today that a new, large naval hospital would be commissioned tomorrow at Pleasanton, Alameda County.

The first group of buildings will contain about 1,000 beds, but the Navy said, "It is expected that the hospital will be greatly expanded as the war progresses."

Captain Robert P. Parsons of the Navy Medical Corps will be commanding officer of the hospital. He recently returned from the Pacific combat areas, where he assisted in establishment of a hospital.—San Francisco *Call-Bulletin*, September 30.

State Medical Society of Wisconsin Holds Meeting with Hospital Groups

(COPY)

THE STATE MEDICAL SOCIETY OF WISCONSIN

Madison, Wisconsin,
August 27, 1943.

To the Secretaries of all State Medical Societies.

Dear Friends:

This year, for the first time, this Society is holding a special section program for chiefs of staff, superintendents of hospitals, members of hospital boards, and others interested in the conduct and administration of these institutions in our state.

An effort has been made to arrange a program that would be of joint interest to physicians and hospitals. A copy of the program is enclosed.

The Chairman of our Committee on Hospital Relations has asked that I obtain from you information concerning similar meetings held in your state. Will you please drop me a note advising me if you have held a meeting similar in character and, if so, how it was received and the degree of success of the meeting.

I will sincerely appreciate your doing this.

Cordially yours,
(Signed) C. H. CROWNHART,
Secretary.

* * *

(COPY)

THE STATE MEDICAL SOCIETY OF WISCONSIN

Madison, Wisconsin,
August 16, 1943.

Chiefs of Staff, Hospital Superintendents, Hospital Board Members, and Others:

Dear Friends:

The Committee on Hospital Relations of the Society has arranged for a special meeting devoted to the subject of "Hospital Relations" as part of the annual meeting program on September 15. Outstanding authorities have been secured to present a program of timely interest to chiefs of staff, hospital superintendents, hospital board members, and others. This program will be presented on Wednesday morning, September 15, in the Milwaukee Auditorium. This meeting will be held at the same time that the one hundred second anniversary meeting of the State Medical Society is held in the Milwaukee Auditorium.

As secretary of the Society it is my privilege to extend to you a most cordial invitation to attend this meeting and to see the many scientific and technical exhibits that will be on display at the Auditorium.

In order that arrangements may be made to accommodate you at the noon luncheon scheduled at the Hotel Schroeder, I would appreciate your returning to me your reservation together with your remittance.

It will be a pleasure to have you attend, as guests of the Society, the morning sectional program.

Cordially and sincerely,
(Signed) C. H. CROWNHART,
Secretary.

COMMITTEE ON HEALTH AND PUBLIC INSTRUCTION

Venereal Rate in State Rises

Sacramento, Oct. 4.—Cases of syphilis reported in both civilian and military reports showed an increase of 43 per cent in the first six months of 1943 over the similar period of 1942, the State Public Health Department announced today.

A similar increase in gonorrhea cases was also reported. "It would appear that war conditions are responsible for these increases," the Department declared.

A good part of the increase in syphilis infections was accounted for by cases involving negroes, the Department reported. Negro cases increased 200 per cent in the six-month period over the previous similar period.

titioners argue not merely that they should not be required to accept the undesired services of medical practitioners, but also that they should not have to pay, directly or indirectly, for such service. If this were a plea, on their behalf, for exemption on this ground, almost any committee on the subject would be glad to confer with their representatives, to see if a feasible plan to meet this situation could be agreed on.

However, those who do not wish medical care for themselves are now paying their share toward providing it for others who do wish it, and we have not heard that they object. They pay taxes to support hospitals and clinics, and to provide medical services and drugs for the indigent. They pay the same taxes as others for the vast cost of the army medical service, and if they are wounded or stricken with disease while themselves serving in the armed forces, they are treated by Army or Navy surgeons. Their employers pay directly (and they indirectly) under workmen's compensation for surgical and hospital care, and even for something toward the cost of rent and food, if they are injured in their work. If their share of the general cost of health insurance were also charged against their wages, it would be rather the extension of an old principle than the imposition of a new one.

But all this has nothing to do with the immediate publicity, which is all quoted from one John M. Pratt, "executive administrator" (in other words, publicity agent) of the "National Physicians' Committee." And his arguments—like those of nearly all the other press agents mistakenly employed for this purpose—consist of slogans and epithets against nonexistent bugaboos.

We have not seen the text of this alleged sickness insurance bill, but if it even remotely resembles the account of it quoted from Mr. Pratt, it could scarcely receive a single vote in Congress and would certainly be repudiated by every informed supporter of health insurance. There were no such provisions in a single health insurance system in the world in the days before the war when every civilized country except the United States had such a system, and this writer at least, who has for fifty years been urging the adoption of health insurance by American States, never heard of any such proposal here—except in the bugaboo publicity of paid lobbyists.

The chief bugaboo, of course, is the phrase "State medicine," which is exactly what legitimate health insurance aims to prevent. We do have State medicine, to be sure, in the Army—where, incidentally, it is the best medical service in the world. Army surgeons are all salaried men, and the wounded soldier does not choose which one will operate on him, nor pay him for doing it. The service in county hospitals for those who cannot pay is also State medicine. And the care of disabled soldiers after the war will be on the same system. We may get more State medicine after the war, as a result of the radical changes which it may produce, even in civil life. But not by reason of the adoption of real health insurance if that comes.

There is room here for only one more bugaboo, which is cost and dictatorship. According to Mr. Pratt's committee, the Surgeon-General of the United States would be its dictator. He would have $3,048,000,000, which would enable him to hire every hospital bed, public and private, in the United States; to hire all its physicians, at $5,000 a year each; and to spend $168,000,000 a year for drugs and $600,000,000 for administrative costs. In addition, he would pay the total cost of operating the medical colleges of the United States, support all the medical students during their courses, and spend $11,000,000 a year on research. And he could get all this staggering sum by the simple bookkeeping entry of transferring it from the Federal Social Insurance trust fund, where it supposedly now is, so that "the cost to the individual family head" of $120 a year would actually cost nobody anything.

"The Committee reports that it is getting an enthusiastic response from many of those to whom it has sent its literature, including 131,000 doctors."

No wonder, if they believe the guff this press agent sends them!

Here, however, is one of them who, like the gentleman from Missouri, waits to be "shown."—San Francisco *Chronicle*, September 7.

Shenanigans of the Medical Trust

(Opinion of a Labor Group)

Some who imagine that the American Medical Association is the sanctified repository of science and who raise an eyebrow when we mention the "medical trust," might be slightly disillusioned by the article we published on Monday, exposing the American Medical Association's attempt to prevent even the mild Social Security measure of the Wagner-Murray-Dingell Bill from passing Congress.

More particularly, the "front" organization of the American Medical Association, going under the high-sounding title of "The National Physicians' Committee for the Extension of Medical Service," is exposed as spending thousands of dollars for propaganda against the bill, propaganda which uses the phraseology of all American Fascists in attacking all social reform.

The attack centers upon the health provisions of the Social Security bill, which is called "totalitarian," "regimentation," and "political medicine," while the present shameful lack of adequate medical care to the bulk of the people, a lack which is responsible for the huge percentage of rejections for disability of draftees by the armed services, is termed—"the Christian concept of the sanctity of human personality—the American way."

Under the health provisions of the bill, known as "Senate Bill 1161," the United States Surgeon-General is empowered to obtain volunteer physicians to work under the health insurance sections of the Act, to arrange for hospitalization and set fees to be paid for work done by doctors. This is the special target of the American Medical Association, which sees the "menace" of an "attempt to abolish private medical practice," though a large proportion, if not a majority, of physicians are eager to extend such medical service and would be materially benefited by it.

The point of all this is that the American Medical Association is engaging in a campaign to kill Senate Bill 1161, by urging all physicians to incite protest locally, to get local Chambers of Commerce and civic bodies to oppose the bill.

The people should be on the lookout for this propaganda, and particularly note that physicians are urged to "try to have your local newspapers carry a story and/or editorial" against Senate Bill 1161.

The people also should take a positive stand in support of Senate Bill 1161, and urge all Congressmen to vote for it.—San Francisco *People's World*, August 26.

COMMITTEE ON HOSPITALS, DISPENSARIES AND CLINICS

Kaiser Steel Mill at Fontana, California, Opens New Hospital

Built and designed to take care of Kaiser steel mill employees and their families, the Southern Permanente hospital was in operation today at the Kaiser iron and steel plant near Fontana.

The new hospital is one of the most modern to be found in this area, incorporating all the newest and latest advances in hospital equipment and technique.

The hospital itself is the remodeled original administration building formerly used by the Kaiser Company, Inc., plus a new wing added to accommodate four-bed wards and surgical units for in-patients. The entire hospital has been modernized with a floor plan designed to permit the easiest accessibility to the rooms of all patients from a central work area, thus speeding the service to each patient.

There are four surgical units, similarly designed, each having accessibility to a central sterilizing work room. The hospital has the most modern types of equipment in design, such as a new-style lighting system for the operating rooms,

The Department also noted the California rate of increase was substantially above an increase reported nationally of 21 per cent.

The Department said separate tabulations of statistics for civilian and military populations are not available and it was impossible to determine the effect of racial groups that have recently migrated into California on civilian rate. —San Francisco *News,* October 4.

Health Education Program

By the San Francisco Heart Committee

A Feature of the Fourteenth Annual Postgraduate Symposium: Public Invited

This program for lay citizens is sponsored by the Second District of the California Congress of Parents and Teachers. To be held at the Mount Zion Nurses' Home Auditorium, 2345 Sutter Street, at 10 a. m., November 5, 1943. An invitation is extended to all who are interested in the prevention of heart disease.

THE MOBILIZATION OF COMMUNITY RESOURCES FOR THE PREVENTION OF HEART DISEASE

S. P. Lucia, M. D., Presiding

Chairman of the Department of Preventive Medicine, University of California. Chairman of the Committee on Health Education

The Federal Program for the Prevention of Heart Disease.—Edith P. Sappington, M. D., District Medical Director, United States Children's Bureau.

State Facilities for the Prevention of Heart Disease and the Care of the Cardiac Invalid—Wilton L. Halverson, M.D., Director of the California State Department of Public Health.

The Position of the Pediatrician in the Program of Preventable Heart Disease—William Palmer Lucas, M. D., Clinical Professor of Pediatrics, University of California Medical School.

The Need for Adequate Convalescent Care for Rheumatic Children.—Miss Ethel Cohen, Regional Medical Social Consultant for the United States Children's Bureau.

The Rôle of the Public Health Nurse in the Program for the Prevention of Heart Disease—Miss Rena Haig, Chief of Public Health Nurses, State of California.

* * *

The prevention of heart disease is a public-health problem. It is of vital concern to the entire community.

To achieve this end the Heart Committee carries on an intensive program of education.

The Heart Committee is a division of the San Francisco Tuberculosis Association.

The Christmas Seals you will buy this year will help support the campaign against heart disease.

Parent-Teacher Association Health Proposal: Preventive Medicine in Preschool Age Group

There has been a tremendous influx of children into this community. Many of these children have had no medical supervision whatever. On September 8, representatives of the Parent-Teacher Association met with a committee of representatives of the Health Council of the Community Chest, San Francisco Department of Public Health, San Francisco County Medical Society, and American Academy of Pediatrics to discuss a program for launching a campaign of preventive medicine in the preschool age group. It was decided at this conference that such campaign should be inaugurated and that the children in this group should be protected against diphtheria, smallpox, pertussis, and tetanus, and that tuberculin tests should be done routinely and Schick tests at the appropriate time after diphtheria prophylaxis is administered.

It was felt by this committee that, so far as possible, all work should be referred to the private practitioner unless the parties involved were unable to pay a reasonable fee. In such cases, these children are to be referred to health centers, clinics, and to the Department of Public Health for their coöperation. It was also advocated that the profession, as well as the above agencies, prepare a comprehensive prophylaxis certificate on which are indicated the various procedures to be carried out, the dosage, the date of administration, and the results; this certificate to be kept safely for future reference by the parents.

The Parent-Teacher's magazine is going to publicize this program, and information slips will be sent to the parents of children of preschool age.

It was suggested that those practitioners called upon for this treatment who are not familiar with the administration of the above prophylactic procedures recommended, inquire of the other members of the profession who have had such experience in order that they may carry out this complete program. The coöperation of the profession in this worthy cause will be greatly appreciated by the committee.—*Bulletin of the San Francisco County Medical Society.*

COMMITTEE ON MEDICAL ECONOMICS

Another Dividend by California State Compensation Insurance Fund, but Not to Physicians

(COPY)

San Francisco, October 1, 1943.

To the Editor:

"Registering a new high mark in unbroken dividend participation over a period of twenty-nine years, the State Compensation Insurance Fund is currently distributing more than $4,250,000 to California employers." This announcement has been made by Paul Scharrenberg, Director of Industrial Relations, and chairman of the Industrial Accident Commission, the Fund's Board of Directors. Fund reports reveal that a favorable accident experience and low operating costs, coupled with the largest annual premium income in its history, have made this showing possible.

Since starting business in 1914, the State Compensation Insurance Fund has distributed $97,000,000 for benefits to injured employees and their dependents, in accordance with the provisions of workmen's compensation laws. A surplus and reserves amounting to $23,500,000 remain on hand. Most of this surplus and the reserves for future payment of incurred claims for injuries are invested in Municipal, State, and Federal Government Bonds. Present total bond holdings of $21,990,000 include $9,866,000 in United States Government Bonds, of which $2,450,000 were acquired during the Third War Loan Drive.

(Signed) STATE COMPENSATION INSURANCE FUND.

War Worker's Lunch Box Far From Adequate.—A survey in Sales Management reveals the mysterious contents of the average war worker's lunch box. Nutrition experts and dietitians would hardly endorse these meals on which millions of workers depend for health and energy. Ninety-nine and nine-tenths per cent of worker's lunch boxes contain sandwiches. Eighty per cent of the sandwiches are made with meat. Desserts, mostly cakes and pies, are found in 65.2 per cent of the boxes. Beverages figure with 34 per cent, coffee predominating. The percentage of vegetables is only 20.4, and salads are not even listed.

Health is one of the two prime requisites for a strong national defense. The other is morale.—Col. William J. Donovan.

COUNTY SOCIETIES†

CHANGES IN MEMBERSHIP

New Members (20)

Alameda County (2)

Puttler, S. D., *Oakland*
Terry, Lawrence, *Alameda*

Butte-Glenn County (1)

Whiting, Frank M., *Oroville*

Humboldt County (1)

James, Herbert C., *Ferndale*

Los Angeles County (4)

Barlow, Nathan J., *Bell*
King, Jack W., *Los Angeles*
Scofield, Jr., Dean Stanley, *Los Angeles*
Schiffler. Robert J., *Los Angeles*

Mendocino-Lake County (2)

Barcklow, George T., *Willits*
Havstad, Gordon, *Fort Bragg*

San Bernardino County (1)

Clarke, George W., *San Bernardino*

San Diego County (6)

Brodie, Earl I., *San Diego*
Guerrero, William F., *San Diego*
Ickstadt, Albert Sr., *Coronado*
Kennedy, C. R., *San Diego*
Lambert, Thomas H., *San Diego*
Taylor, Merrel H., *San Diego*

San Mateo County (2)

Myers, Philip R., *San Mateo*
Zillmer, A. L. W., *Burlingame*

Yuba-Sutter-Colusa County (1)

Frantz, John Russell, *Oakland*

Transfers (3)

Abbott, F. E., from Los Angeles County to San Diego County.
Miller, Edward A., from San Diego County to Orange County.
Saylin, Joseph, from Los Angeles County to Orange County.

Retired Members (1)

Bartle, Ira B., *San Luis Obispo.*

In Memoriam

Chapman, William H. Died at Loma Linda, August 19, 1943, age 66. Graduate of the University of Nebraska College of Medicine, Omaha, 1902. Licensed in California in 1910. Doctor Chapman was a member of the Riverside County Medical Society, the California Medical Association, and a Fellow of the American Medical Association.

✠

Gregory, Frank Starr. Died at San Mateo, August 21, 1943, age 68. Graduate of Cooper Medical College, San Francisco, 1900. Licensed in California in 1900. Doctor Gregory was a member of the San Mateo County Medical Society, the California Medical Association, and a Fellow of the American Medical Association.

†For roster of officers of component county medical societies, see page 4 in front advertising section.

Lowe, Wilfred Francis. Died at Sacramento, September 11, 1943, age 40. Graduate of Rush Medical College, Illinois, 1930. Licensed in California in 1930. Doctor Lowe was a member of the Sacramento Society for Medical Improvement, the California Medical Association, and a Fellow of the American Medical Association.

✠

McCarthy, Harry Lloyd. Died at Los Angeles, July 25, 1943, age 65. Graduate of the University of Pennsylvania School of Medicine, Philadelphia, 1910. Licensed in California in 1920. Doctor McCarthy was a retired member of the Los Angeles County Medical Association, the California Medical Association, and an Affiliate Fellow of the American Medical Association.

✠

Wolf, George Lawrence. Died at San Francisco, August 21, 1943, age 62. Graduate of the College of Physicians and Surgeons of San Francisco, 1917. Licensed in California in 1917. Doctor Wolf was a member of the San Francisco County Medical Society, the California Medical Association, and a Fellow of the American Medical Association.

THE WOMAN'S AUXILIARY TO THE CALIFORNIA MEDICAL ASSOCIATION†

MRS. CHARLES C. LANDIS.....President
MRS. ROGER McKENZIE.....Chairman of Publicity

A MESSAGE FROM THE PRESIDENT

Dear Auxiliary Members:

At no time in the history of our organization have there been so many calls for the attention, time, and interest of our Auxiliary members as at the present. We must grant that many of the calls are urgent and worthy of our best in coöperation and service. Yet, because we are human, and it is impossible to answer all the calls upon our time, it behooves every doctor's wife to stop and weigh the relative value of the services that she may render to our country during this crisis.

Is there any greater service within our power than to help in maintaining the high standards of American medicine while our doctors are doing their utmost in caring for the armed forces and the civilians? There are forces at work even now that would make the practice of medicine in the postwar days a very different matter than it ever has been. Shall we, as doctors' wives and Auxiliary members, overlook the opportunities there are for service in directing the minds of the lay public to an appreciation of the results of these measures?

Our country needs strong men and women and healthy children in this crisis. Shall we allow, by our absorption in more trivial matters, the leadership in health education to pass to the cultists and faddists?

The amount that each one may do, personally, may seem small, but united as a group in the Auxiliary, our influence will be felt and a great deal can be accomplished. The State Board, in session in Oakland during this past month, approved the plans submitted by the Committee Chairmen to guide in the work of the Auxiliary this year. These have been mailed to the county presidents. Choose from the suggested plans the ones that are best suited to your community needs and the talent of your members.

† Prior to the tenth of each month, reports of county chairmen on publicity should be sent to Mrs. Roger McKenzie, 138 Twenty-fifth Avenue, San Francisco. For roster of state and county officers, see page 6, in front advertising section.

Let us extend our hospitality in every possible way to the wives of the doctors in the armed forces, helping them to contact the Auxiliary wherever they may be located.

As a special project this year, we urge that each Auxiliary lay plans for placing *Hygeia* in all high school and college libraries, in the reading rooms of the Army camps and the U. S. O. I am sure that there is no place where the authentic information contained in this magazine will be more appreciated.

Each Auxiliary member should be informed regarding Senate Bill No. 1161, and be able to explain it to the lay public. Copies may be secured by writing to the National Physicians' Committee at 55 East Washington Street, Chicago. It is recommended that we contact our Senators and urge their active opposition to this bill.

April has been designated as "Cancer Control Month" by act of Congress. As we plan our programs, let us keep this in mind and give it the emphasis it deserves.

There are many ways by which money can be raised for the Medical Benevolence Fund. This is more needed than ever. Let us do all we can to support this worthy program.

As soon as the new War Participation Committee completes its plans, copies will be sent to each Auxiliary. It is hoped that under this committee our war activities may be coördinated so that our war work as a group may be more effective.

There are many other activities that our Auxiliaries are already maintaining. Let us do our part on the home front so that when the men return they may find that the freedoms for which they have fought have not been destroyed.

Wishing you each a most successful year,

MRS. C. C. LANDIS, *President.*

* * *

MEETING OF THE BOARD OF DIRECTORS

The fall meeting of the Board of Directors of the Woman's Auxiliary to the California Medical Association was held at the Claremont Hotel in Berkeley, California, on Wednesday, September 8. There were sixteen members present and fourteen county presidents. Mrs. C. C. Landis, president, was unable to be present due to illness, and her absence was greatly regretted. Mrs. Franklin Farman, first vice-president, ably conducted the meeting.

Reports of various officers and committee chairmen and outlines of the year's work occupied the membership. Among plans submitted for the year were work on the Wagner-Murray-Dingle Bill, aid in recruiting members for the U. S. Nurse Cadet Corps, continued support of the Medical Benevolence Fund, and the work of a new committee on war participation.

The Board was fortunate in having the National president, Mrs. Eben Carey, address them at this meeting. She outlined successful activities in various State Auxiliaries, such as the Doctors' Aid Corps in Georgia and the Supplementary Speakers' Bureau in Wisconsin. Mrs. Carey explained the main project for the year as given by the Council of the American Medical Association, namely, aid in procurement of members for the United States Nurses' Cadet Corps. High school graduates from 17 to 35 years are eligible. They must pass a rigid physical examination and after being accepted may choose the training school they prefer. For the first nine months they receive $15 per month, plus room, board, uniforms, and laundry. For the next ten months, as Junior Cadets they receive $20 per month plus the above extras, while the last ten months of training they are Senior Cadets and receive $30 per month with maintenance. Aid in recruiting may be given through newspapers, Speakers' Bureau, Parent-Teacher organizations, clubs, labor groups, and booths in department stores. Girls already in training may transfer to the Corps.

At noon the meeting adjourned for luncheon, where Mrs. Carey and Dr. George H. Kress were guests of honor.

At the afternoon session the regular business was completed. Later a tea, honoring Mrs. Carey, was given at the home of Mrs. Julian Lunsford by the Alameda County Auxiliary. This gracious gesture was deeply appreciated and enjoyed.

MRS. LAWRENCE GUNDRUM,
Recording Secretary.

CALIFORNIA PHYSICIANS' SERVICE†

Beneficiary Membership

Commercial (August, 1943)		49,010
Rural Health Program		5,000
War Housing Projects (approximate)		29,559
Marin	5,844	
Los Angeles	7,024	
San Diego	.....	
Vallejo	15,035	
San Francisco	1,656	
Total		83,569

Through the instrumentality of the Federal Public Housing Authority, in coöperation with California Physicians' Service, the continuance of medical services for tenants in housing projects has been assured. This is the result of conferences held by California Physicians' Service representatives and the Housing Authority in Washington.

The great and vital need for this service in housing projects was evident to all concerned, and the implications of its discontinuance could have been of major consequence. This was evident to the Coördinating Committee of Procurement and Assignment Service, to the State Department of Public Health, the United States Public Health Service, and the Social Security Board. Through the combined efforts of all these agencies in pointing out the need to Washington, everything that could be done within the legal set-up of the Federal Public Housing Authority has been effected.

The plan provides for prepayment on the part of the Housing Authority in areas certified as to the need by Procurement and Assignment Service to continue with the staff of physicians and nurses that California Physicians' Service has built up during the past nine months. The necessity for smooth continuance of the service is quite evident because of the increasing shortage of doctors, and due to the recognition of the fact that it would be almost impossible to develop a new staff at any known future date.

It is gratifying to have the reaction of the tenants concerned, and of the Housing Authorities concerned, to the effect that California Physicians' Service has rendered a valuable and necessary service, which was evidenced by the vocal expression on their part in the form of petitions, etc., to Washington, pointing out the urgent need for the continuation of this type of program.

* * *

As a result of this action, medical care programs will continue in Marin, Los Angeles, Vallejo, San Francisco, the Fairmont Trailer Camp in Contra Costa County, and

†Address: California Physicians' Service, 153 Kearny Street, San Francisco. Telephone EXbrook 0161. A. E. Larsen, M. D., Secretary.

Copy for the California Physicians' Service department in the OFFICIAL JOURNAL is submitted by that organization.

For roster of nonprofit hospitalization associates in California, see in front advertising section on page 5, in left-hand column.

the program will go into Alameda as a new plan. These plans will be operating under temporary sixty-day agreements, during which time some permanent plans can be developed.

In contacting the local Housing Authorities, most of them evinced an interest in continuing with the prepaid feature that characterized California Physicians' Service's original plan. Being offered to the tenants is a contract with the same benefits included, directed at protecting the health of the community. The rates were left the same—that is, $2.50 for a single person, $4 for a married couple, and $5 for a family of three or more. Excluded from the contract were obstetrical care, which had taken such a large proportion of the income, tonsillectomies, herniotomies, and correction of congenital defects. The figures of the past nine months' experience indicate that with these items deleted, and with the assurance of at least 90 per cent participation of all tenants, the program is financially sound.

In the meantime, service is continuing in all of the areas, which is extremely vital at this time because of the approach of the winter months, when the incidence of illness is expected to increase considerably.

The attitude and understanding of the physicians involved during the period of uncertainty, and in the face of continuing service for practically no fee, is to be commended. It is also of interest to note that in many of the projects the families continued on with their prepaid dues during the entire period. There was little loss of membership during the last couple of months.

On Events in Federal Housing Areas in California

The meeting of California Physicians' Service representatives and others, with Federal Housing Authority officials in Washington, D. C., was preceded by conferences in San Francisco, concerning which a statement of July 30, 1943, by Dr. A. E. Larsen, Secretary of California Physicians' Service, gives further information:

CALIFORNIA PHYSICIANS' SERVICE

July 30, 1943.

Enclosed find copy of a letter which was recently sent to all housing authorities with which California Physicians' Service has entered into contracts to render service in the Federal Housing Projects.

You are undoubtedly aware that the California Physicians' Service program is inadequately financed, to the point where we cannot continue to ask local physicians to accept the insufficient fees for services that we are able to pay. This notice follows out of a sequence of meetings with the Coördinating Committee of the Procurement and Assignment Service of the War Manpower Commission, which adopted the following resolution:

"It is the considered opinion of this Committee that the present method of furnishing medical care to residents of housing areas, through California Physicians' Service, is the most desirable method known to the Committee under present circumstances, and we recommend that the Federal Public Housing Authority be urged to take all steps necessary, within its authority, to obtain the necessary funds to insure that this program shall be continued."

The second meeting was with all of the housing authorities concerned, which adopted a resolution which we quote in part:

"1. It is essential that medical care be made available to residents of War Housing Projects.

"2. It is agreed that California Physicians' Service is the only medium through which such service can be made available in these critical war areas."

A third meeting was held with all of the governmental agencies concerned with war production, together with the United States Public Health Service, State Department of Public Health, and the California Medical Association. A resolution was adopted by this group as follows:

"Resolved, that the Federal Public Housing Authority be requested to recognize the great need for medical care in housing projects in communities that cannot be provided for by any other means, and that the FHPA be requested to authorize local housing authorities to enter into such contracts with California Physicians' Service as may be necessary and desirable for insuring the continuation and extension of the California Physicians' Service program."

We hope to get speedy action on this combined public sentiment. It will be necessary that this matter be taken to Washington for final decision. We shall keep you informed from time to time of subsequent developments.

In the meantime, we should like to urge upon participating physicians the necessity of continuing to discharge our contractual responsibility. It is to be remembered that the financial position of the housing projects in no way affects the regular California Physicians' Service program for commercial groups.

Very sincerely,

A. E. LARSEN,
Executive Medical Director.

* * *

CALIFORNIA PHYSICIANS' SERVICE

San Francisco, July 29, 1943.

Mr. Albert J. Evers, Executive Director
Housing Authority of the
City and County of San Francisco
525 Market Street
San Francisco, California

Dear Mr. Evers:

In accordance with the terms of the Medical Service Agreement entered into between California Physicians' Service and the Housing Authority of the City and County of San Francisco, dated April 19, 1943, we hereby notify you that our agreement to render service thereunder will terminate as of September 30, 1943.

We sincerely regret the necessity for the termination of these arrangements, but our experience to date indicates the obvious impossibility of financing the costs of these services out of present income. During the period from September, 1942, to May, 1943, inclusive, California Physicians' Service professional members have rendered services of which the total cost in all projects throughout the state amounts to $365,000. Our total income from tenants of housing projects during the same period was $241,000.

We believe that every effort has been made by the Housing Authority and by California Physicians' Service to make the present program successful, and we wish to express our appreciation for the assistance and coöperation that you have given to us in attempting to make this necessary service available to the tenants of housing projects.

Very sincerely,

A. E. LARSEN.
Executive Medical Director.

C. I. O. Acts to Save Health Project for Harbor Area

Los Angeles, Sept. 10.—Los Angeles C. I. O. Council's Executive Board is urging an immediate conference of the Federal Housing Authority, California Physicians' Service, tenants of harbor housing projects and organized labor in an effort to save the lowcost medical service at the Banning and Wilmington housing projects.

Inadequate financial returns and opposition by county medical societies are the main reasons why California Physicians' Service intends to terminate its services on September 30 unless it gets a new contract calling for subsidies by the Federal Housing Authority and greater limitations of the plan.

The California Physicians' Service is a voluntary prepayment medical plan which operates under the auspices of the California State Medical Society in conjunction with the Blue Cross Hospitalization plan.

The housing authority furnishes quarters and equipment. The doctors make available specialist care and hospitalization outside of the projects at the relatively low cost of $2.50 for an individual, $4 for a man and wife, and $5 for a family unit, to be collected with the tenants' rent if he chooses to avail himself of the service.

What a discontinuation of the health program would mean to California is indicated by the C. I. O. statement that tens of thousands of workers are about to be deprived of even a minimum of medical care "threatening thereby not only the immediate community of the housing projects, but the West Coast as a whole with epidemics and general health deterioration."

The C. I. O. Executive Board recommended to all agencies concerned that the low-cost medical program be continued under any circumstances. At the same time the C. I. O. appealed to the U. S. Public Health Service for immediate allotting of physicians' and nurses' services in the event that contract negotiations with the California Physicians' Service are fruitless.—San Francisco *People's World*, September 11.

Steps Taken to Continue California Physicians' Service In Vallejo

A most serious crisis threatens Chabot Terrace if the California Physicians' Service withdraws its activities on September 30 as planned, according to Ray Martin, 412 Siskiyou Avenue, Chabot Terrace, who was appointed chairman of the "Save the California Physicians' Service" Committee at a business meeting of the CCCC's Monday evening.

Mr. Martin pointed out the obvious hazard to the community in case of epidemics in the face of the present shortage of nurses and doctors. He pointed out the financial record of the Chabot Medical Center as evidence that it cannot operate without a better contract. It must break even at least. In May the total income was $13,486.15 and the total expenditures, $19,555.76, leaving a deficit of $6,069.61.

A plan was evolved Friday at a meeting at Harbor Gate Project in Richmond which Mr. Martin attended, calling for every housing project in the bay area to petition Washington to make it possible for the California Physicians' Service to be retained.

Thursday and Friday of this week, August 26 and 27, petitions will be circulated in Chabot Terrace. Everyone interested in the welfare of his family is asked to sign the petition and to help in its circulation. Those willing to assist are asked to see Mr. Martin or Project Services Office.—Vallejo *News-Chronicle*, August 25.

References to Article by A. W. Meyer

(Continued from page 214)

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(Continued from page 224)

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MEDICAL EPONYM

Stokes's Collar

William Stokes (1804-1878) first described this phenomenon in the *Dublin Journal of Medical and Chemical Sciences* (5:400-440, 1834), in an article entitled "Researches on the Diagnosis and Pathology and Aneurysm." He discusses a case of aneurysm of the aorta as follows:

"I was at once struck with the peculiar appearance of the neck. This was generally enlarged (giving the idea of the patient's wearing a collar or tippet), the jugular veins were turgid and tortuous."

He also mentions the phenomenon in the first part of *A Treatise of the Diagnosis and Treatment of Diseases of the Chest* (Dublin, 1837, page 231) and again in *The Diseases of the Heart and the Aorta* (Dublin, 1854, page 573), as follows:

"As an indication of intrathoracic tumor, an extremely varicose state of the superficial veins of the neck and thorax is probably less frequent in aneurismal than in cancerous diseases. The pressure may be exercised on the venae innominatae or the superior cava. . . . In other cases we find that in place of the large tortuous veins ramifying on the surface, there is a puffy elastic swelling of the entire neck. To this may be given the name of tippet-like swelling of the neck."—R. W. B., in *New England Journal of Medicine*.

MISCELLANY

Under this department are ordinarily grouped: News Items; Letters; Special Articles; Twenty-Five Years Ago column; California Board of Medical Examiners; and other columns as occasion may warrant. Items for News column must be furnished by the fifteenth of the preceding month. For Book Reviews, see index on the front cover, under Miscellany.

NEWS

Coming Meetings†

California Medical Association. Meetings will be held in San Francisco. Date of the seventy-third annual session, to be held in 1944, to be announced later.

* * *

American Medical Association. Place and date of 1944 annual session to be announced later.

The Platform of the American Medical Association

The American Medical Association advocates:

1. *The establishment of an agency of Federal Government under which shall be coördinated and administered all medical and health functions of the Federal Government, exclusive of those of the Army and the Navy.*

2. *The allotment of such funds as the Congress may make available to any state in actual need for the prevention of disease, the promotion of health, and the care of the sick on proof of such need.*

3. *The principle that the care of the public health and the provision of medical service to the sick is primarily a local responsibility.*

4. *The development of a mechanism for meeting the needs of expansion of preventive medical services with local determination of needs and local control of administration.*

5. *The extension of medical care for the indigent and the medically indigent with local determination of needs and local control of administration.*

6. *In the extension of medical services to all the people, the utmost utilization of qualified medical and hospital facilities already established.*

7. *The continued development of the private practice of medicine, subject to such changes as may be necessary to maintain the quality of medical services and to increase their availability.*

8. *Expansion of public health and medical services consistent with the American system of democracy.*

Medical Broadcasts*

The Los Angeles County Medical Association:

The following is the Los Angeles County Medical Association's radio broadcast schedule for the current month, all broadcasts being given on Saturdays.

KFAC presents the Saturday programs at 11:45 a. m., under the title, "Your Doctor and You."

KFAC will present these broadcasts on the following Saturdays: October 2, 9, 16, 23, and 30.

The Saturday broadcasts of KECA are given at 11:15 a. m., under the title, "The Road of Health."

"Doctors at War":

Radio broadcasts of "Doctors at War" by the American Medical Association, in coöperation with the National Broadcasting Company and the Medical Department of the United States Army and the United States Navy, are on the air each Saturday at 2 p. m., Pacific War Time.

† In the front advertising section of *The Journal of the American Medical Association,* various rosters of national officers and organizations appear each week, each list being printed about every fourth week.

* County societies giving medical broadcasts are requested to send information as soon as arranged.

Pharmacological Items of Potential Interest to Clinicians*:

1. *Special Issues:* Congratulations to Benno Schwabe & Co., Basle, for the special chemotherapy number (19/20) *Schweizerische Medizinische Wochenschrift,* 1943, dedicated to the International Committee of the Red Cross. Pages 549 to 685 deal mostly with sulfonamide derivatives in various clinical conditions, with general discussion by R. Stachelin, H. Staub, M. Hartmann, and R. Meier on basic principles, and bibliography of 958 articles by O. Merkelbach. Interesting how little United Nations' scientific or medical publications have reached Switzerland since 1942. But even the University of Basle offers special courses in tropical medicine. To be noted are F. Verzar's *Theorie der Muskelkontraktion* and A. L. Vischer's *Das Alter als Schicksal und Erfüllung;* also the new *Helvetica Physiologica et Pharmacologica Acta,* quarterly at Fr. 31.50, if you can get it! The June, 1943 issue of the *Bulletin of the American College of Surgeons* (28:90-239) is all war, from care of the injured to a selected bibliography. The July issue of CALIFORNIA AND WESTERN MEDICINE has a tuberculosis supplement (59:25-71, 1943) which deserves wide circulation, reprinting, and a lot more rayrah; most of the notes warrant extension and republishing.

2. *And More Books:* C. C. Thomas (now in Frank Lloyd Wright's Springfield (Illinois) house, announces I. H. Page's *Hypertension*—a manual for patients; and C. C. Higgins' *Renal Lithiasis. New and Nonofficial Remedies* (A. M. A., Chicago, 1943 issue), continues to show improvement in organization and material. Williams & Wilkins (Baltimore) issue B. Ratner's *Allergy, Anaphylaxis, Immunotherapy.* Macmillan (New York, 11) offer W. K. Livingston's *Pain Mechanisms: A Physiological Interpretation of Causalgia.* P. B. Hoeber has another W. C. Alvarez on *Nervousness, Indigestion and Pain,* and has ready a big *Clinical Tropical Medicine,* edited by A. T. Bercovitz. Finally, there appear both volumes of the important *Pharmacology of the Opium Alkaloids,* by H. Krueger, N. B. Eddy, and M. Sumwalt (Suppl. 165, Pub. Health Rep., Washington) with a whopping bibliography of over 10,000 items! American Council of Public Affairs, Washington, issues S. Wilson's *Food and Drug Regulation.* Symposium of Association for Research in Nervous and Mental Diseases on *Rôle of Nutritional Deficiency in Nervous and Mental Disease* is published by Williams & Wilkins. And we have just received the same outfit's *Antigonadotropic Factor with Consideration of the Antihormone Problem,* by B. Zondek and F. Sulman. Also note *Cytology and Cell Physiology,* edited by G. Bourne, and including sections by J. F. Danielli and H. Blaschko, offered by Oxford Press at 20s. C. C. Thomas published *Medical Progress Annuals,* covering series of articles appearing in the *New England Journal of Medicine.*

3. *Interesting:* J. Davidson finds body-louse eggs develop 25 per cent per day at body heat (*Med. J. Austral.,* 1:533, June 12, 1943). R. H. Williams and G. W. Bissell confirm E. B. Astwood's finding (J. A. M. A., 122:78, 1943) that thiouracil successfully controls thyrotoxicosis in doses of 0.2 gram per four hours, giving blood concentration of 3 milligrams per 100 cubic centimeters, and 300 milligrams per day in urine (*Science,* 98:156, August 13, 1943). F. R.

* These items submitted by Dr. Chauncey D. Leake, formerly director of the University of California Pharmacologic Laboratory, now dean of the University of Texas Medical School, Galveston, Texas.

Winton & Co. report renal damage after crush injury to limbs (*Quart. J. Exp. Physiol.*, 32:89, 1943; M. C. Sanz (Bern), in studies on brain metabolism, finds no acetylcholine production in absence of glucose and increase in metabolism with HCN (*Pfluger's Arch. ges. Physiol.*, 246:597, 1943). G. Domini and H. Rein (*ibid.*, p. 608) confirm our old report that lactate ions dilate peripheral vessels independently of pH (*Am. J. Physiol.*, 80:107, 1926). H. Kwiatowski (*J. Physiol.*, 102:32, 1943) finds much histamine in distal parts of sensory nerves, none in central nervous system or motor nerves, proposes histaminergic nerves. B. C. Bose and B. Mukerji discuss physiologically active fractions of Indian hemp (*Nature*, 152:109, July 24, 1943). In July *Physiological Reviews* are articles by E. F. Hirsch and S. Weinhouse on lipids in atherosclerosis; L. Pauling & Co. on antigens, antibodies, and precipitation reaction; and F. A. Hellebrandt on vertical stance of man.

4. *Ave. Helvetica Physiologica et Pharmakologica Acta*, O. A. M. Wyss, Geneva, Editor. First issue contains articles by S. Burgi on tegmental reaction; A. Fleisch on Vitamin A; W. R. Hess on subcortical centers; W. Bloch on relation of hypothalamus to resp. metab.; W. Schuler on relation between age and metabolism; and proceedings, January 30 meeting of the Swiss Society for Physiology and Pharmacology.

Ninetieth Birthday of San Francisco County Medical Society.—The San Francisco County Medical Society cordially invites members of the California Medical Association to attend the meeting in celebration of its ninetieth birthday on Sunday, November 7. Clinics in general medicine and general surgery will be conducted in the morning at Lane Hall, Stanford University Medical School, and Toland Hall, University of California Medical School.

"The Future of Medicine" will be the subject of a symposium to be held in the afternoon at the home of the County Medical Society. Dr. Morris Fishbein of Chicago, Dr. Walter H. Brown, chairman of the Department of Hygiene, University of California, and other speakers to be announced later, will participate.

Governor Warren Appoints Two Members to State Health Board.—Governor Warren on September 28 appointed Dr. Sanford Moose of San Francisco and Dr. Samuel J. McClendon of San Diego to the State Board of Health.

They replace, respectively, Dr. V. A. Rossiter, Santa Ana, deceased, and Dr. F. W. Pottenger, Los Angeles, resigned.

Birth Rate Jumps in War.—In its first full year of World War II—1942—the nation's birth rate was the highest in sixteen years and the death rate the lowest on record.

The Census Bureau so reported on September 25. Births totaled 2,808,996, an increase of 11.8 per cent over the 1941 figure, and deaths, not counting war casualties abroad, numbered 1,385,187, a decline of 0.9 per cent from the preceding year.

United States Health Picture "Favorable," Says Office of War Information.—The Office of War Information today painted a "generally favorable" picture of United States civilian health despite a shortage of doctors which will continue to increase "indefinitely," barring revision of military requirements.

Summarizing the results of its second survey of the nation's medical defenses, OWI found 108,000 physicians—out of the total prewar registry of 180,000—still available to care for the remaining civilian population of 120,800,000 persons.

If this total were perfectly distributed, OWI said, it would mean one doctor, in general practice, for every 1,557 persons—very close to the desirable ratio of one to 1,500. Perfect distribution does not exist, however, and is not attainable without compulsory shifts of doctors to critical localities.

"Undoubtedly, the most acute health problem affecting the nation as a whole arises out of the increasing shortage of doctors and dentists," the report stated. "The shortage . . . will continue to increase indefinitely unless the requirements of the armed forces are revised."

The Office of War Information said, however, that the armed forces so far have commissioned only a little more than 80 per cent of their needs and also are taking 80 per cent of all new medical graduates. Only 1,500 of the 7,000 new medical graduates each year will be available to replace the 2,500 to 3,000 doctors who die annually.

Despite the shortage of physicians, OWI found the increased rate of sickness among war workers no greater "than might be expected under the strain of war-time living and working conditions."

A 68 per cent increase during the first quarter of 1943 was reported in worker absences of eight days or longer because of respiratory diseases, particularly influenza and grippe.

State Health Talks at C. I. O. Parley.—Dr. Wilton L. Halverson, Director of the California State Department of Public Health, was one of the speakers at an all-day health conference of the Los Angeles C. I. O. Council on Sunday, September 19.

"Health Joins the C. I. O." will be a working conference at which C. I. O. union delegates will have a chance to set up a full-time health division within the C. I. O. Council, and to share in the planning of the program for such a division.

Among the speakers was Dr. Morris Raskin, medical coordinator of the Medical Research Institute of the UAW, and a pioneer in union health planning. Doctor Raskin discussed Industrial Health as it affects the workers, and how unions can help safeguard the health of their fellow workers.

The topic of Medical and Hospital Care was discussed by Dr. Asher Gordon, resident physician at the Vallejo housing project and a member of California Physicians' Service, a prepayment group medical plan.

Dr. Henry Borzook, professor of biochemistry at the California Institute of Technology and his coworker, Miss Nancy Upp, field director of the Los Angeles County and City Committee for Nutrition in Industry discussed how we can keep our workers at the highest level of efficiency through proper feeding methods in the plants.

Dr. Clyde K. Emery discussed the proposed Wagner-Murray-Dingell Social Security Bill and its health and hospitalization aspects.

The conference was open not only to elected delegates, but to the entire membership of the Los Angeles C. I. O. Council. Interested representatives from public and private health agencies received invitations to attend as observers.

Infantile Paralysis in Sonoma County.—Dr. E. D. Barnett, Sonoma County health officer, left on September 1 for Buffalo, New York, to present a report at the American Hospital War Conference.

In a summary of infantile paralysis cases cared for at the Sonoma County Hospital, where he is medical supervisor, Doctor Barnett stated that of 70 patients treated up to August 28, 44 were males and 26 were females; that 52 per cent of those admitted as victims were between the ages of three and twelve years; that 56 per cent had head-

aches as symptoms, 50 per cent stiff necks, 55 per cent muscle pains, 38 per cent fever, and 19 per cent were suffering from apprehension and displayed extreme restlessness.

His report also showed that 19 per cent had "sore throat," 18 per cent vomited; 84 per cent had back muscles affected, 69 per cent had weaknesses in their hamstrings; 52 per cent were affected in the diaphragm muscle, and 52 per cent in the abdominal area.

Venereal Disease Medicine Needs Doctor's Approval.—Medicines for the treatment of venereal diseases can be sold in California only upon the prescription of a duly licensed physician.

Dr. Wilson L. Halverson, Director of the State Department of Public Health, announced this on September 6, saying the new regulation is provided in a law passed by the last legislature. The restriction also provides that prescriptions containing the sulfonamide drugs cannot be refilled without a doctor's order.

In announcing the new law, Doctor Halverson praised the druggists who, he said, in the majority of cases had complied voluntarily with the provisions of the law before the legislation was passed.

"Only a skilled physician can treat venereal diseases successfully. Self-treatment and inadequate treatment often make syphilis and gonorrhea more difficult to cure," Doctor Halverson said.

He added that local health departments maintain free public clinics where anyone can receive diagnosis and emergency treatment. Continued free treatment is given patients unable to pay a doctor's fee. The State Department of Public Health provides free antisyphilitic drugs to doctors in private practice for the treatment at a reduced rate of patients who cannot pay the full charge.

Two Thousand Five Hundred Use San Francisco Medical Telephone.—Nearly 2,500 persons, mostly newcomers to San Francisco, engaged physicians during the past three months through the San Francisco County Medical Society's "around the clock" telephone service bureau, it was announced recently.

The Society established the telephone bureau as a public service especially for newcomers to the city and for old-time residents whose doctors had departed for the war. The Society's membership was first polled to locate physicians who could take additional patients, and doctors who could take night calls.

Government Fiscal Statistics.—A Washington dispatch of September 25 gives the following summary of Government expenses and receipts for the current fiscal year through September 23, as compared with a year ago:

	This Year	*Last Year*
Expenses	$ 20,621,580,896.54	$15,009,688,011.42
War spending	19,076,051,240.10	13,543,150,516.03
Receipts	8,976,010,581.89	3,599,624,606.89
Net deficit	11,645,570,314.65	11,407,909,054.53
Cash balance	15,422,135,848.46	2,736,665,910.78
Working balance	14,659,438,645.27	1,974,186,793.69
Public debt	158,830,956,110.02	88,246,514,290.55
Gold reserve	22,204,723,013.48	22,750,375,074.42

Doctor Disagrees With Two of Sister Kenny's Practices.—A United Press item states that Dr. Joseph Moldaver of the Columbia University College of Physicians and Surgeons' Department of Neurology expressed disagreement with two of Sister Elizabeth Kenny's theories about poliomyelitis.

In an article in *The Journal of the American Medical Association,* Doctor Moldaver emphasized, however, that his criticisms were concerned in no way with the Kenny treatment methods.

Sister Kenny believes, he said, that infantile paralysis victims suffer "mental alienation" of muscles, meaning that the muscles around the paralyzed area are dissociated from the brain.

This mental alienation of muscles does not exist, Doctor Moldaver said. Studies of forty-nine victims of the disease showed that the muscles lose their power because the anterior horn cells are damaged or destroyed, he said.

Muscle spasm, contraction of muscles, is regarded by Sister Kenny as the most serious and damaging symptom in the disease, Doctor Moldaver said. The danger of paralysis lies mainly in allowing the spasms to continue, she believes.

"Muscle spasm is not the most dangerous symptom," Doctor Moldaver said, "and it does not lead to nerve and muscle degeneration."

Number of Doctors in San Francisco Is Plenty for City's Needs.—San Francisco has plenty of physicians to attend its sick.

This announcement was made on September 23 by Dr. Harold A. Fletcher, State Chairman of the War Manpower Commission's Procurement and Assignment Service.

A survey conducted in San Francisco by the Service disclosed there were now 1,253 physicians actually caring for the sick in San Francisco, indicating, he said, that 474 doctors have entered military service from this city since 1940. Some of the 1,253 physicians, Doctor Fletcher said, are engaged part time in research, laboratory work or other activities not directly connected with the treatment of ill people.

"There is no need to worry about the medical coverage of San Francisco at the present time," Doctor Fletcher said. "There are 816 general physicians, specialists in children's diseases, and general surgeons practicing here. In addition, there are 437 specialists in all the various medical specialty branches.

"The most recent population figures show 691,609 people in the city, which means that the ratio of doctors to population is greater than one to 600, with all the specialties well represented. For a city the size and character of San Francisco, a ratio of one to 1,000 would be considered very reasonable medical coverage, and a ratio of one doctor to 1,100 or 1,200 people would not be considered a dangerous condition."

Although there are enough doctors for quite adequate medical care, Doctor Fletcher said there is an actual shortage of hospital beds, which, however, has not yet had a bad effect on the community's health, but might during the winter months.

Research Group Leader Named.—The Board of Directors of Government Research, Inc., have elected John R. Richards president and will meet on October 5 to name an executive secretary.

Officers serving with Richards are Dr. Elmer Belt, vice-president, and Dean E. Christy, treasurer. Frederick N. Edwards is acting as counsel.

Seventy-five new members have been received in the past month, and the rate of applications received is increasing. The organization announced a membership of more than 5,000 interested citizens is being planned.

The organization has offices in charge of Mrs. Dorothy Dickinson at 411 West Fifth Street.

Dr. Courtney Smith New Area Medical Officer.—Dr. Courtney Smith, formerly assistant commissioner of health in the Territory of Alaska, recently took over his new duties as regional medical officer for the Ninth Civilian Defense Region, succeeding Dr. Fred T. Foard, now assigned to the Eighth Public Health Region in Denver, according to an announcement by George L. Levison, regional OCD director.

Pleasanton Naval Hospital Open.—The U. S. Naval Hospital at Pleasanton, Alameda County, accommodating one thousand patients, was formally commissioned recently by Rear Admiral Daniel Hunt, district medical officer.

Captain Robert P. Parsons, recently returned from duty in the Pacific combat area, will be in charge of the new hospital.

"KAISER WAKES THE DOCTORS": A BOOK REVIEW*

Kaiser Wakes the Doctors. By Paul de Kruif. Cloth. Price, $2. Pp. 158. New York: Harcourt, Brace and Company, Publisher, 1943.

Foreword.—The editorial, "An Author, de Kruif, Finds in California the Solution of Future Medical Practice," states that excerpts from the book "Kaiser Wakes the Doctors," a copy of which has been sent to CALIFORNIA AND WESTERN MEDICINE for review, would appear elsewhere in this issue.

The excerpts referred to are here used as the basis for a review of Author Paul de Kruif's book. This seems to be as good a method as any for bringing to the attention of readers the nature and scope of Author de Kruif's views.

The excerpts, in quotations, in each instance appear in light-face type, followed by the reviewer's comments in italics. No doubt, other answers will also occur to readers. If space were available, additional comment could be made. Book review follows:

Book Review: Excerpts and Comments

"This book had its initial spark in a little story, 'Tomorrow's Health Plan—Today!,' published in the May, 1943 issue of *The Reader's Digest.*"

Comment.—At a luncheon at one of the clubs in San Francisco at which some twenty or more guests were present, Mr. de Kruif told the story of the above article—how it had been rewritten and rejected a dozen or so times before acceptance. The thought flits into the mind that his book may contain some of the ideas he incorporated in his initial drafts. The May, 1943 article referred to was an interesting statement.

* * *

"The banging, clanging, rhythmic flow of men and steel into a Liberty ship, complete from keel to launching within five days, is not the most epochal event at Henry Kaiser's shipyards."

Comment.—Citizens, everywhere, share in the admiration for the splendid organization procedures Mr. Kaiser and associates have brought into being in their shipbuilding and other wartime industries. When de Kruif begins Chapter I of his book with the above sentence, he overlooked the man-hours, covering many days, needed in the building of a ship. Newspapers have told that story.

* * *

"So, under Henry Kaiser's guidance, it is the workers themselves who are building the model of a Mayo Clinic for the common man. Here where there is no money consideration between the sick man and his physician, you see a blueprint for group medical practice for the common man, for the powerful preventive medicine of our doctors for tomorrow."

Comment.—If deducting fifty cents per week from the pay of each worker, to cover sickness insurance supplied by the attending physicians, is not a "money consideration," what is it?

* * *

"What have I [de Kruif] done to fight for the medical underdogs, the medical have-nots? Their numbers are far greater than those who in the great depression were ill-clothed, ill-housed, ill-fed."

Comment.—Social welfare workers would probably take issue with de Kruif on the above, and would be tempted to call attention to the fact that poverty, which causes people to be "ill-clothed, ill-housed, ill-fed," is an important causative factor in many illnesses; and that there are many more poverty-stricken persons than there are of the group of human fellows, to whom the author refers to as "medical underdogs."

* * *

"Like any other form of insurance, these prepaid medical care plans have spread the risk, so that sick people's unbearable financial burden might be shared by those who are well. But here was the catch: these prepaid medical care plans were *medically* not popular: it was the organization of the doctors themselves who opposed them."

Comment.—The large number of "prepaid medical plans" which are in operation throughout the United States, with full coöperation of physicians, is the best answer to the above.

* * *

"About medical care he [Mr. Kaiser] was fanatic."

Comment.—Did Author de Kruif look up the meaning of the word "fanatic"? The Oxford English Dictionary states: "Fanatic . . . affected by mistaken enthusiasm . . . an unreasoning enthusiast."

Did de Kruif wish to give such a meaning to Mr. Kaiser's labors?

* * *

"Then he [Mr. Kaiser] uncovered one of the secret weapons that he was sure would bring us victory in America's coming fight for nation-wide health. 'We won't need Government handouts,' he explained, with fire in his eyes and a slow smile. 'Our medical chief, Doctor Garfield, has proved at Coulee Dam, and is proving now at Richmond shipyards, that if you properly organize and distribute the burden of payment for the best kind of hospital and medical care, the hospitals will quickly amortize themselves; *they'll pay themselves off!*'"

Comment.—With the type of set-up in operation in specialized fields of industrial endeavor, with a particular group of what might be called selected risks, with money cost deducted from pay envelopes without acquisition expenses, etc., and with additional income from state compensation funds to the amount of 40 per cent for industrial injuries, it may be possible for "hospitals to quickly amortize themselves."

Not so, however, when both sexes and all ages are cared for under altogether different conditions. A study of the history of hundreds of hospitals, from one end of the United States to the other, will emphasize this.

* * *

"Even if the manufacturers would go for his plan [Mr. Kaiser's], seeing as how good medical care would lower their man-hours, vastly raise their production—even so, could Kaiser convince the doctors? The physicians whose voices are most powerful in organized medicine are specialists who make good livings on fees, not from the common but from the *un*common man. 'These specialists largely guide the medical rank and file. Will they be interested?' I asked."

Comment.—The statement concerning "physicians whose voices are most powerful in organized medicine" is not in accord with the facts. The biographical files of the American Medical Association in Chicago contain abundant proof to the contrary.

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* For editorial comment, see page 207.

"He [Kaiser] had it clear that, under the individualism of private practice, all was not too secure with the bread and butter of scores of thousands of little doctors."

Comment.—Who and where are these "scores of thousands of little doctors" whose "bread and butter . . . is not too secure"?

If they exist by the "scores of thousands," it should not be difficult for de Kruif and company to point some of them out.

* * *

" 'Remember [Author de Kruif speaking of himself] that your life is justly said to be a series of enthusiasms.' "

Comment.—After perusal of the de Kruif book, one is much tempted to concur in the author's diagnosis of his own condition.

* * *

"The tough part of it would not be convincing the industrialists: they didn't mind stronger manpower. The tough job wasn't convincing the bankers: they would love financing hospitals and health centers if these were a sound investment. And the people—no, 135,000,000 American people would not mind prepaid medical care, for which they all would equitably pay, which would relieve them of their pain, sickness, misery, and needless death."

Comment.—The reason bankers have been reluctant to finance hospitals has been due to their actuarial and other knowledge which proved to them that many hospitals are not "sound investments."

And de Kruif is very much in error when he states "135,000,000 American people would not mind prepaid medical care." The experience of California Physicians' Service with some 7,000,000 inhabitants of that State bears testimony on this point. Healthy people are not yet enamored of prepaid medical care, and without the coöperation of this group, the excessive proportion of poor risks will always endanger the actuarial soundness of voluntary sickness insurance plans.

* * *

"And the people? Alas, they were not organized, they were inarticulate. The voice of the common man could not reach the doctors."

Comment.—What a lack of understanding concerning the lives of physicians!

If there is one group whose members do hear the "voice of the common man," it is the doctors. Let de Kruif read Robert Louis Stevenson's tribute to physicians.

* * *

"He [Kaiser] believed that what he had begun for more than 100,000 shipbuilders could be done, too, for smaller industries, for communities rural as well as industrial."

Comment.—This is a statement of very broad scope not in harmony with past experience. As stated in the editorial comments in the current issue, logical conclusions are dependent on sound premises.

* * *

"Garfield—with a vision of the new death-fighting possibilities of group medical teamwork—had begun his experiments in modern medical care as a lone wolf in the southern California desert. He had graduated from the excellent University of Iowa Medical School and then had migrated to the modern Los Angeles County Hospital, where the lucky poor people of the region get medical science better, on the average, than that of the middle or even the upper economic brackets. Here Garfield, during his years of service as an intern and a surgical resident, had it burned into him *why* the treatment of the poor man, the 'medically indigent,' is so superior."

Comment.—The writer had the privilege of serving on the attending staff of the Los Angeles County Hospital for more than twenty-five years during all of which time he was also a member of its medical executive board. Therefore, he should know somewhat about the institution. Good as the ward and other service rendered by that hospital may be, it is not in accord with facts that in its wards "the lucky poor people of the region get medical science better, on the average, than that of the middle or even the upper economic brackets," who are under the care of the Los Angeles physicians who are in private practice. These same physicians give their services without cost to the County Hospital patients. How absurd it would be for them, since they earn their living in private practice, to give the latter group a lesser quality of service. The author's statement refutes itself.

* * *

"What it boiled down to for the men was that they felt they owned this health plan; they'd all helped pay for it. What it meant for the doctors was that, when there was no money consideration between them and their patients, there was the chance for simple Christianity to come in. Exit dollars—enter God."

Comment.—Rather interesting. The author would seem to imply that physicians in private practice do not carry on their work in accord with the principles of "simple Christianity."

And from whence and how did he receive the message, "Exit dollars—enter God."

* * *

"That day he [Henry Kaiser's son] had taken his noon meal at the best hotel in Richmond, California, close by the Kaiser shipyards. 'There were a lot of shipyard workers eating in that dining room; and you should have seen the right-hand side of the menu card—prices like the Waldorf in New York,' said Edgar. [Mr. Kaiser's son] 'The men were ordering *pheasant*. They were liking it. Believe me, they're not going to forget they once earned money enough to order pheasant,' said Edgar, laughing, and in his laugh there was the ring of high approval. If a manager thinks pheasant is okay for the workmen, he is not likely to let them down on their medical care."

Comment.—Some out of the ordinary premises for a peculiar conclusion.

* * *

"There is no trouble getting modestly paid men to spend the equivalent of half a pack of cigarettes a day when they know that this will guarantee them the best unlimited medical attention."

Comment.—The statement is not in harmony with experience in medical service plans. California Physicians' Service gave unlimited service and found it could not be successfully carried through. The author had access to the California Physicians' Service reports and yet makes the above statement.

* * *

"The family prepaid health plan was advertised and announced at union meetings. It was an unexpected flop. Within three months' time, only some 10 per cent of the workmen's wives and children had signed up for it. What actually happened was what has defeated the bookkeeping of more than one voluntary health insurance plan. The wives and children were not signed up for it, most of them, *until they took sick*. You can see how this threatened to wreck Garfield's set-up."

Comment.—The above presents interesting contrast to the statement quoted from a preceding page.

If persons to be covered do not sign up "until they took sick," it is easy to understand why a prepayment plan will break on financial rocks.

" 'The most amazing part of the whole thing,' said Garfield, 'was that when we had the plan started and well along in operation, people stopped dying.

" 'That sounds funny, but actually what it meant was that people came to us; the reason they stopped dying was the fact that they came to us with their early symptoms."

Comment.—It is granted that, in a limited number of cases, lives are saved by early treatment. Prepayment plans help to this end, but not to the extent that "people stopped dying."

* * *

"If we free their hands, if we let them use all their science, our doctors can do more than merely mend bone and brain and muscle. They can build faith and courage in the common man."

Comment.—Physicians have been building "faith and courage in the common man" from the beginning of recorded history and their hands have been "free" always.

* * *

"Kaiser's keymen, his two sons, Edgar and Henry Jr., included, were driven to the limit of their strength, and then beyond it, yet kept on working. Henry Kaiser himself enjoyed it. To supercharge his natural super energy, the giant [Mr. Kaiser] demanded more and better vitamins. New pills of these powerful chemicals were recommended to him. . . ."

Comment.—What were these wonderful vitamins? And are they prescribed for all the shipyard workers? In connection therewith, reference may be made to a newspaper dispatch of a few days ago, in which it was stated that in a new concentrated food packet for shipwrecked soldiers and sailors, a few vitamin pills were placed to fill vacant space in the packages, because, owing to wide press publicity concerning vitamins, the pills helped in the sustaining of morale.

* * *

"Then he [Doctor Garfieid] explained that the whole project would pay itself off reasonably quickly from the money rolling in from the weekly 50-cent pieces voluntarily prepaid by 30,000 workers, plus fees from their industrial compensation insurance."

Comment.—If the above is applied to, say, 100,000 workers in the Kaiser shipyards, the following calculation concerning income may be made: The daily nickels on the basis of fifty cents per week, or two dollars per month, in twelve months, say for 100,000 workers, would mean an income of $2,400,000. Add to that 40 per cent more for the income received through state compensation payments, a sum then in excess of $3,000,000.

When the income is received by the central plant, with acquisition and administrative costs held down to a minimum, in a group of selected risks of sufficient size or mass spread, it is quite easy to understand how "the whole project would pay itself off reasonably quickly."

* * *

"By the time Kaiser had returned West, Garfield was ready with a smart idea, really a wonderful idea, put into his head by his medical friend, Dr. Ray Kay. 'You and Mrs. Kaiser can make it a Foundation,' Garfield said. 'A Foundation not for profit. Then when our health plan has paid this one off, with all the money coming in we can do great scientific things; we can build *new* hospitals, more hospitals. . . .' "

Comment.—Concerning the Permanente Foundation, brief comment was made thereon in CALIFORNIA AND WESTERN MEDICINE *(December, 1942, on page 344). The Foundation was established by a loan from Mr. and Mrs. Henry Kaiser.*

"So the Permanente Foundation was founded by Henry and his wife, Bess Kaiser. This young Doctor Garfield might have all the figures to prove this was a wonderful investment, but the bankers were very pleased with Henry Kaiser's signature on the $250,000 loan."

Comment.—Reference has been made in a previous excerpt to the attitude of the bankers. Here it is shown that the banking fraternity were taking no chances in relation to the establishment of the Permanente Foundation. They protected themselves by having Mr. Kaiser sign on the dotted line. This is no reflection on the bankers. They are custodians of the money of citizens and are obligated to show proper caution in protecting the interests of their clients.

* * *

"This immunity of doctors from really effective mass indignation was undoubted. And, during the past twenty years, their remarkable advances—for which we must thank the doctors—made medicine too costly for the common man. So it was inevitable, since the individual sick man must pay his doctor, that doctors will go where sick folks have the dough. This had brought about a maldistribution of medical care that stank to high heaven."

Comment.—Some readers may hold that the verb used in the past tense in the last sentence of the above could be used with even more justice to the author's comments as given in his last two sentences.

* * *

"So the spread of these groups had remained feeble. Their number had remained small in proportion to the millions of our medical have-nots. And for a reason. From Chicago, headquarters of the American Medical Association, down through every state and county medical society from coast to coast, there reached an invisible but powerful hand. This hand was ready to give the works to any physician who'd go off the reservation by daring to serve a medical coöperative on a full-time salary.

"How, then, faced with the necessity of the medical care of 30,000 workers where the medical societies were powerful, would Garfield recruit a staff of good surgeons and physicians?"

Comment.—Whose is this "invisible but powerful hand" that de Kruif talks about as existing in the American Medical Association headquarters at Chicago?

In a long experience in organized medicine, the writer has yet to have his first experience with such an "invisible but powerful hand." The total number of licensed physicians in the United States is about 176,000. Component county medical societies are the sole judges of the conduct of their members and in such matters are independent of their respective state associations and also of the national organization.

The "invisible but powerful hand" myth is a figment of imagination held by persons not familiar with the facts.

For information concerning the second paragraph in the above excerpt, reference may be made to the article by the California Procurement and Assignment Service which appeared in CALIFORNIA AND WESTERN MEDICINE *for January, 1943, on pages 23-26.*

* * *

"Shall the people have a say in how to pay their doctors? Or shall organized medicine dictate how physicians shall be paid? Or else, no doctor—even if you're going to die?"

Comment.—Do citizens dictate to merchants how they will decide to pay for goods purchased, or do merchants lay down the conditions of payment for their goods?

And the follow-up sentence in the excerpt, isn't it far-fetched?

"In the American Medical Association there are powerful constituent bodies, like the California Medical Association and the Michigan State Medical Society, that are actually fighting to bring about prepaid medicine."

Comment.—For these kind words, thanks.

* * *

"So with the national organization of our physicians. It is run by a few men in the little smoke-filled room. Of this fact the medical rank and file are not aware or to it they are indifferent. With this fact many of our most competent doctors are disgusted."

Comment.—The governing body of the American Medical Association is its House of Delegates. California is represented by eight delegates, who are elected by their California colleagues on the basis of the reputations for service which they have established. So also in other states. If "many of our most competent doctors are disgusted" with this plan of democratic organization, a better procedure will be welcomed.

* * *

"This was what haunted Garfield: the invisible hand from Chicago."

Comment.—Again, "the invisible hand from Chicago," Who, and What, and Why?

* * *

"Yet, if Garfield manned his Permanente Hospital with medical stumble-bums—always available a dime a dozen—his health plan was sure to fail. The hospital would jam up with sick people who would not get well. The workman would reject the health plan. Its income would dwindle. Kaiser would be left with that $250,000 note to which he had signed his name. And Garfield? He would be ruined."

Comment.—Author de Kruif here uses language not in keeping with dignified thinking or discussion. To apply the term "medical stumble-bums" to physicians whose services Doctor Garfield would reject, is out of place.

De Kruif insists that the physician in private practice is to have no money relations with patients, but financial considerations seem to be in order when the financial interests of Mr. Kaiser or Doctor Garfield are involved.

Referring to the California Procurement and Assignment Service report on the Permanente Foundation in California and Western Medicine *for January, 1943, the following paragraph is quoted from page 24:*

"Doctor Garfield, according to these statements, is employed under an agreement which allows him to draw up to $25,000 annually in salary. To date, he states, he has drawn no salary from the funds of the Foundation, but has actually put into current operating funds some $10,500 of his own money. When and if the profit period of the Foundation is realized, it is anticipated that Doctor Garfield will draw his $25,000 annual salary, will be repaid his $10,500 advance and will have no further share in any profits accruing from the plan."

* * *

"Yet now, in spite of these sinister possibilities, Sidney Garfield began hiring highly trained young surgeons and physicians. He was quiet, but he was strangely persuasive."

Comment.—Concerning the hiring, the Procurement and Assignment Service report previously referred to stated:

"Early in its existence in California, Procurement and Assignment Service became aware of the building up by Mr. Kaiser and Doctor Garfield of a staff of physicians for both the industrial and nonindustrial medical care of Kaiser employees. The Kaiser staff of some thirty physicians (early in 1942) represented a group of young men, all but two of whom were definitely of military age.

"A review of the Kaiser medical staff showed that practically every one of the thirty physicians should be declared 'available for military service' because of his age; at the same time, Procurement and Assignment Service had no intention or desire to break up an established staff which was caring for an important segment of the industrial population. . . .

"At the same time, Procurement and Assignment Service put Doctor Garfield on notice that his staff members were vulnerable to induction into the Army by Selective Service because of their low average age. This warning was given for the protection of the staff, to obviate the disruption that might occur if a large part of the staff was classified 1-A by local draft boards and forced into military service." . . .

* * *

"This question of rooms versus wards during the terrific expansion of enrollment of workers on the health plan was a point of hot debate between Doctor Garfield and Henry Kaiser. The seventy-bed Permanente Hospital had no sooner opened in late August, 1942, than it was deluged beyond its capacity by the Kaiser army swarming up from its original 25, to 50, 70, 90,000 shipbuilders. Sidney Garfield—it was his duty as a doctor—wanted to take care of them all, rooms or no rooms. Henry Kaiser—fanatical believer in a medical golden rule—maintained that if he himself should have a private room, then so should every worker, down to the humblest laborer or shipyard sweeper."

Comment.—Hospital executives will find much of interest in the above.

* * *

"He [Henry Kaiser] got the $300,000 [more] without his signature [to an additional note]. It encouraged the bankers that, three months after the opening of Garfield's health plan, the original $250,000 loan was paying itself off at the rate of $25,000 a month!"

Comment.—Why it is possible to pay off a loan at that rate is easily understood when the income received in the Richmond shipyards and previously discussed is taken into consideration.

* * *

"Garfield offered his doctors salaries that ranged from $450 to $1,000 a month—not bad for a young physician or surgeon just out of hospital residency and facing the cold world of medical competition in individual practice. So between August, 1942, and March, 1943, Garfield's staff at the shipyard first-aid station, the Field and Permanente Hospitals had grown to a group of sixty well-trained physicians and surgeons."

Comment.—The Procurement and Assignment Service report previously quoted reflects interesting sidelights on the above.

* * *

"They [the doctors who were hired by Doctor Garfield] rubbed their eyes in amazement at Doctor Garfield's new medical economics. His organization's total income came, 40 per cent of it, from payment by industrial insurance companies for workmen's compensation insurance medical care. The remaining 60 per cent came from the individual 50 cents a week from the prepaid health plan voluntarily subscribed to by the Kaiser workers.

"Under this plan what could the doctors give the sick workers for their seven cents a day?"

Comment.—The above is given to emphasize the source of the Permanente Foundation's massive income of hundreds of thousands of dollars. With money received in such great amounts, it is not to be wondered at that Doctor Garfield is able to hire physicians on individual salaries running up as high as $1,000 per month.

* * *

"Of course their excellent salaries, with no overhead, are a good reason for the notably high enthusiasm and

morale of Garfield's staff of doctors. But there is a deeper cause for their spirit that you remark about them on their rounds of medical mercy to the great army of the industrially wounded and the sick. On a vast scale it confirms Sidney Garfield's discovery made in the desert. There and at Grand Coulee he had begun to be thrilled by what happened to his doctors when the cruel barrier of money was lifted from between them and their patients. Exit dollars—enter God."

Comment.—When Author de Kruif refers to Doctor Garfield in the above, ending again with the sentence, "Exit dollars—enter God," how does he explain the "$25,000 annual salary" or more received by Doctor Garfield, referred to in the Procurement and Assignment Service report?

* * *

"On this vast scale Garfield and his staff were demonstrating a revolutionary new medical economy. In the five months following the health plan's opening, the workers had paid $500,000 into the health plan; for this they had received the equivalent of more than $1,500,000 worth of treatment, when you estimate it on the fee-for-service system by which the individual pays his individual doctor."

Comment.—Along the same line of reasoning, and with the same fee-schedule estimations used in the Permanente computations above, it would be of interest to have the contrasting grand total of many millions of dollars that represent the value of the professional services gratuitously and unostentatiously given by California physicians in the county and other charitable hospitals of the State.

* * *

"This weapon was the possibility of putting doctors who were stepping off the reservation of medical 'ethics'—into the Army. The Federal Procurement and Assignment Service had the duty to gather physicians for our armed forces. Now the officials of Federal Procurement and Assignment, and its state and local boards were—most of them—also high in political power in the American Medical Association and its constituent state and local societies. Of course, you see that fact's significance."

Comment.—The implication in the above might be called "nasty." The splendid group of physicians who as Medical Procurement and Assignment Service officers have given gratuitous service to our country deserve fullest commendation. That is the significant fact, not what de Kruif states.

* * *

"The scientific medical teamwork, the swift mending of smashed skulls and broken bodies, the rapid diagnosis and cure of early pneumonia, the expert healing of burned eyes, the modern management of diabetes, high blood pressure, and wrecked hearts, the surgery of appendicitis, perforating stomach ulcers, and the scientific treatment of cancer—all this could not be done with men whose only qualification was a plain 'M. D.' Garfield's health plan was modern group medicine or it was nothing."

Comment.—What is modern hospital care if, in one sense, it is not "modern group medicine," where attending staff members confer with and utilize one another's knowledge and facilities in the treatment of seriously ill patients?

* * *

"Now the physicians of California came to the rescue. Their leaders had smashed a cruel taboo by going out of their way publicly to approve Kaiser's prepaid medical care. Now in this emergency where illness, and even death itself, threatened hundreds of thousands of women and children, the California doctors awoke. Through their California Physicians' Service they believed they could undertake the care of this vast cohort of the medically forlorn."

Comment.—De Kruif gives to his book the title "Kaiser Wakes the Doctors." In the above he states "the California doctors awoke." California Physicians' Service was established several years before the Kaiser shipyards came into existence, and the California Medical Association contemplated the formation of California Physicians' Service even several years before that.

The California doctors, therefore, even according to de Kruif, evidently awakened themselves. The awakening did not come through Mr. Kaiser.

* * *

"Now the California Physicians' Service was ready to go into death-fighting action. Before Pearl Harbor, its organization by California medical leaders had got the California Medical Association into the doghouse with the invisible hand that ran the American Medical Association."

Comment.—Again, the question is asked, To whom did this "invisible hand that ran the American Medical Association belong" that "got the California Medical Association in the doghouse"?

Members of the California Medical Association would be pleased to have this information, because they, themselves, know of no such power.

* * *

"The workers—by their voluntary weekly fifty-cent pieces—not only paid for their care, but built those facilities themselves. That was the big news. It ought to thrill you doctors. You don't have to get your facilities by begging them from the rich; you don't have to get them by Government handout.

"Who'd manage the bookkeeping of this prepaid medical care? Industry, not the doctors, who don't pretend to be businessmen and admit it. Kaiser dealt his cards, face up, across the table."

Comment.—Wherein lies this difference in bookkeeping? Physicians have kept their own bookkeeping accounts for years. What bookkeeping magic is this which only "Industry, not the doctors," is able to manage?

* * *

"Now in March, 1943, only six months after the Permanente Hospital had opened, came evidence of the mighty economic power of Garfield's prepaid group medicine. The sum accumulating from the individual seven cents a day from 60,000 Kaiser workers had not only paid for the upkeep and the lavish equipment of those hospitals. But, together with income from compensation insurance mandatory under California law, it was paying off the original sum advanced by Henry Kaiser for the building of the Permanente Hospital at a rate of $50,000 monthly. Within two years of that institution's opening, *the $550,000 needed to build and to equip it would be paid off in full.*

"This super-speedy self-liquidation was new in medical history. It dazed ordinary doctors, accustomed as they were to practice in hospitals that were tax-supported, or wallowing, because of their high overhead, in a morass of debt. It drew indignant bellows of unbelief even from certain eminent experts in prepaid medical care. Their incredulity was based not on any examination of the Kaiser health plan's bookkeeping. It came from a weakness common to all experts."

Comment.—In a previous page, de Kruif was making the payments to the bankers at the rate of $25,000 each month. Now it is up to $50,000 monthly. Would that de Kruif had also given information concerning salary lists and the reserves. A comparison of the administration expenses and "high overhead" would also be of interest.

* * *

"Practicing individually, each doctor has to sell himself. This is obvious if he is to be successful. It results in the super-bedside manner, which has no relation to real medi-

cal ability. In the group the *organization* is the selling point. For instance, Mayo Clinic sells each doctor in the organization by *its* reputation. The doctor doesn't fritter away his time kidding John Smith by his bedside manner. He can devote his efforts to good medicine.

"Individual practice doesn't permit ready consultation. The waste of the patient's time in going from one medical building to another for each specialty is enormous."

Comment.—Not what one would call an excellent example of coherent thinking.

* * *

"Henry Kaiser believes that we can begin right now to build these Mayo clinics for the common man wherever there are industries. Even where the industrial units are small, their managers and their men can pool their efforts to build health-center hospitals that can be used in common. He is a great believer in good, not cut-throat, competition, and thinks the new prepaid group medicine will be stronger if its units are kept small."

Comment.—For other comment concerning the above, see in this issue the press item quoted in the editorial department.

* * *

"Garfield has calculated that community groups of 2,500 people can build, support, and pay off their hospital facilities.

"Then there are other 'experts' who wail that this may be all right in cities, but that it will be no go in rural regions where farmers notoriously have not got the ready money. Again Kaiser has the answer. The economic power of health plans of industrial regions is a tremendous one. When the hospitals there are paid off, then they will make formidable sums of money. . . . And this money can then overflow—with urban and rural citizens coöperating—to build small hospital health centers in rural regions.

Comment.—It is to be hoped that Mr. Kaiser, Doctor Garfield and those who hold to the above will put their plan into execution in two or three dozen places in California and other states.

* * *

"His [Kaiser's] heroes in tomorrow's new fight for life are the doctors. He looks forward to the return of a vast commando force of young physicians from the Army. They are no longer enthralled or misled by the reactionary double talk of organized medicine's invisible hand. They have practiced group medicine, *good* medicine, upon the soldiers and they know its beneficent power. Already they are laughing at the horse-and-buggy individualistic medicine of yesterday.

"The new hospital health centers will be the workshops where the power of the science of these young men will begin to work a fantastic transformation upon our nation now living, so large a part of it, half alive. The great economic power of the new prepaid medicine practiced in these health centers will give a new lease on life to our older doctors, too. Joining these health plans as the California physicians are now joining Kaiser's, there will be the wherewithal for them to become reëducated, to become teamworkers, happy that they, too, can join in the group medicine of our new fight for life."

Comment.—More will be known about all the above when colleagues now in military service return to take up work in civil practice.

The "invisible hand" evidently frets author de Kruif because here it is, bobbing up again.

* * *

"It [new hospital health centers and workshops] can abolish the misery and the insanity of women's change of life. By the skilled use of the new powerful hormones it can extend the sexual activity and lengthen the vigorous prime of life of men, so that we will no longer say that we grow old too quick and wise too late."

Comment.—Here Author de Kruif almost transposes himself into the rôle of an optimistic therapeutist.

* * *

"Large industries, groups of small ones, groups of doctors today left at home, the labor unions, the farmers' organizations—all should band together now to demand the Government Medical Loan Agency. This would guarantee to the local bankers 50 per cent of any losses which might come as a result of the banks' willingness to finance these new Mayo clinics for the common man.

"Then for tomorrow Kaiser sees a still brighter promise. 'How shall we reward the scores of thousands of young doctors who've risked their lives at the fighting fronts in the war?' he asks. 'Death has awakened these doctors.

" 'We should urge that the Government provide them with an extra compensation, and special encouragement for the health centers that they will be ready and anxious to organize. The Government might well guarantee these returning doctors not 50, but 80 per cent of the cost of building their needed facilities.' "

Comment.—Author de Kruif evidently holds that the Government will be generous with doctors. How does he reconcile with his above sentiments the thirty-five-dollar fee table established by the Federal Children's Bureau which has been discussed in this and previous issues?

* * *

Here endeth the book review. G. H. K.

* * *

As a sample of the complimentary book reviews the de Kruif book is receiving, the following, which appeared in the San Francisco *Call-Bulletin* for October 7, is given space:

Books on Parade

"Kaiser Awakes the Doctors"

By Paul de Kruif

(Harcourt, Brace & Co., $2)

Henry Kaiser has done another tremendous job—he has provided medical care for his industries on the prepaid plan at the rate of 7 cents a day per person. Nothing is too good for the crudest laborer.

How Mr. Kaiser accomplishes this task is a stirring story of battles with bankers, and the American Medical Association, and of numerous problems in establishing a hospital. Fortunately he met young Doctor Garfield, who already had made a name for himself, for his hospital in the rugged desert country. Impressed by this project, Mr. Kaiser backed every idea he had for the Permanente Hospital, near Oakland, which is now a significant success.

Immediately absenteeism lessened and workers became more efficient. Mr. Kaiser says, however, "that they got more than efficiency—that they also got greater confidence and faith, and more courage." So now there is more than just the clanging and banging of steel that goes into a Liberty ship. There is the spirit of the men behind it.

"Kaiser Awakes the Doctors," by Paul de Kruif, is a dramatic and inspiring record of achievement.

* * *

Also, in connection with the foregoing excerpts from Author de Kruif's book, the following article, which appeared in the San Francisco *News* for October 7, may be of interest. Some of the statements which follow are very similar to thoughts expressed in the volume by de Kruif:

KAISER HOSPITAL ("CAN'T BE DONE") ENDS GOOD YEAR

(Nick Bourne, first newspaperman to go through the controversial Henry J. Kaiser nonprofit hospital, tells how the plan works and what the doctors have to say both for and against the experiment.—The Editor.)

By Nick Bourne

The nonprofit health plan "which couldn't succeed—the doctors won't stand for it" at the great Henry J. Kaiser

shipyards at Richmond today ended its first year of providing unlimited medical and hospital care to 70,000 shipyard workers for 50 cents a week.

I went through the half-million-dollar hospital, interviewed the patients, nurses, and doctors, obtained the first year's financial statement and learned three things:

1. It works, at least during wartime.
2. Why it works.
3. What the patients and doctors think of it.

The plan, depression-born in the scorching Mojave Desert of California during Mr. Kaiser's work on the 900-mile Los Angeles aqueduct twelve years ago, has grown up by necessity of war in the teeming shipyards.

Largest United States Project

The year's statement of services rendered, money collected and spent, the gratitude of patients, growth of the organization and its imposing building, bespeak the wartime success of the venture, largest United States prepaid medical plan, according to A. L. Brodie, manager.

Each employee joining voluntarily pays 50 cents a week from his pay check. First year's payments, $1,229,331.52, bought 838 major operations, 4,652 minor operations, 47,024 days of hospitalization, 73,797 x-rays and many other services, including free medicine.

Doctors, mostly young Stanford University medical school graduates, do a mass-production, assembly-line job; receive salaries of $450 to $1,000 a month, depending on responsibility and seniority.

Payment in advance overcomes the human frailty of failing to provide for emergencies, according to Mr. Brodie. It has been estimated 40 per cent of Americans never pay for medical attention. they either never get it, or don't pay when they do.

Here is what the doctors on the job here think of the experiment:

DR. WILLIAM W. SAUNDERS, x-ray department head, Stanford graduate: "I doubt if I would have the net income I receive here if I were in private practice. But I do three times a normal amount of work. I like it. I think we do our patients a good turn and they appreciate it. 'Outside' doctors don't like it; it's against the A. M. A. tradition to have patients assigned to a doctor.

Don't Sell Anything

DR. CECIL C. CUTTING, chief surgeon, Stanford, '35: "From the doctor's standpoint, the principal features are that the doctor does not have to be a businessman; has a close contact with associates in his own special field; doesn't have to worry over making a living or the patient's ability to pay his rent, his nurse, for his equipment; we can take each case to its logical conclusion regardless of cost.

"We don't have to sell anything except medical attention and are free to encourage research, progressive ideas, get the best facilities."

But some expressed misgivings:

"Dr. Noseglasses: "It may end up with Kaiser or some other businessman controlling the medical profession and deciding to pay all doctors $130 a month."

Dr. Black Moustache: "We are working toward an inescapable conclusion—Government-controlled 'socialized' medicine. That would get us into politics. Bureaucracy would halt progress."

Dr. Black Moustache: "This idea isn't new at all. It worked in Scandinavia for years."

"Up to Doctors!"

Dr. Van Dyke Beard: "It's up to the doctors, themselves, to control this system. If the doctors won't, business will and we may all be punching time clocks."

Dr. Baldhead: "Then we might join a union!"

The astonishing thing about the patients is that they usually are not very sick. They pay 50 cents a week for unlimited medical and hospital care and want to be sure to get their money's worth. One demanded that his dandruff be cured, or he'd quit. He was told he could hire a private physician or beauty specialist any time he wanted to.

"We do not get many ruptured appendices or advanced cases of pneumonia simply because they all flock in here (1,373,611 clinical calls during the first year) and we catch their trouble before it's serious," explained Dr. Cecil C. Cutting, chief surgeon.

I wandered down the corridors. No wards. All private or semi-private rooms, spotless, modern, with Venetian blinds.

Illness knows no color line here. Red-helmeted men, women welders, negroes, lined up for a checkup by the busy young doctors.

In one double room was Miss Katherine Rossi, shipyard loan office employee, here from Duluth, Minnesota, for six months; ill six months from skin trouble. A negro woman was in the adjoining bed.

"So help me!" declared Miss Rossi. "I've been in hospitals before, but never one like this. It's sure swell. I don't know what I would have done."

The doctors are working hard to keep the men building ships.

One summed up nonprofit medicine:

"The operation was a success—but the doctor died."—San Francisco *News*, October 7, 1943.

MEDICAL JURISPRUDENCE†

HARTLEY F. PEART, ESQ.
San Francisco

A release given to a person whose negligence caused injury bars a malpractice action by the injured party against a physician for alleged negligent treatment which it is claimed aggravated the injury.

It is generally the law that where a person sustains injuries as the result of the negligence of a third person (for example, in an automobile accident) and thereafter consults a physician who further aggravates the injuries in the course of his treatment, the aggravation caused by the malpractice of the physician is considered an injury directly resulting from the original accident and the negligence of the third party. The injured person may, therefore, recover from the negligent third party any damages he suffers as a result of the physician's act.

This rule is subject to the qualification that, in the selection of a physician, the injured person must use reasonable care to choose a physician of ordinary competence and skill. If he does so, the law considers that he has one cause of action in which he may recover from the person first causing the accident for all damages he has suffered, even though some of the damage is directly attributable to the malpractice of the physician treating the injuries.

An application of this rule is illustrated by the case of *Ash* vs. *Mortensen*, 60 A. C. A. 286, decided August 13, 1943. The Court there denied the plaintiff recovery against a physician for malpractice, holding that a release of a cause of action against an automobile driver for personal injuries resulting from an automobile accident bars a subsequent recovery against a physician for alleged malpractice aggravating the injuries.

The plaintiff suffered comminuted fractures to the femur bones of both legs in an automobile accident. One month after the accident she filed suit against the operator of the car and recovered a judgment of $15,000. At the trial of the case the physician had testified that the plaintiff would not be able to walk normally for at least a year, that she might be crippled for life, and that there would be shortening of both legs. All of the testimony as to plaintiff's condition referred to her condition subsequent to her treatment by the testifying physician, and the jury was instructed that, in determining the amount of damages to be awarded plaintiff, they should consider not only the condition of the plaintiff at the time of the trial, but also her condition as it would exist in the future.

The operator of the car satisfied the judgment and obtained a full release from the plaintiff as to all claims arising out of the accident.

Thereafter, plaintiff filed suit against the physician who had treated her for the leg injury and who had testified at the trial, contending that he had failed to exercise ordinary

† Editor's Note.—This department of CALIFORNIA AND WESTERN MEDICINE, presenting copy submitted by Hartley F. Peart, Esq., will contain excerpts from the syllabi of recent decisions and analyses of legal points and procedures of interest to the profession.

care and skill and had carelessly treated the fractured bones. The defendant physician in his answer denied the alleged malpractice. In addition, he raised the affirmative defense that in the prior court action against the operator of the car, all elements of damage to the plaintiff had been considered and, therefore, the resultant judgment and satisfaction fully released and discharged not only the operator of the car, but also the physician from all responsibility for any damages sustained by the plaintiff. Even though the physician had not been a party to the prior action, the Court upheld this defense, ruling that the release given by the plaintiff to the operator of the car barred an action for malpractice against the physician who had treated plaintiff's injuries in an allegedly negligent manner.

The Court said:

"Plaintiff was at liberty to sue Wubben (operator of the car) for the damages she suffered in the automobile collision. But when she elected to sue him, her election was her decision to recover all damages resulting from his negligence and this included the aggravation to her injuries as a result of the physician's neglect. Having proceeded against Wubben, her judgment against that gentleman is a bar to her recovery against the doctors whose negligence might have aggravated the injuries received from Wubben's automobile. Evidence of plaintiff's condition subsequent to the treatment by defendants and her condition as it was anticipated in the future, must be deemed to have been a part of the basis of the jury's verdict."

The theory upon which the decision is based is that a person may not recover twice for the same injuries. Since the jury in the action against the operator of the car must be held to have considered her present condition and her anticipated future condition resulting directly from the accident and the alleged negligence of the physician, plaintiff had already recovered for all damages she had suffered.

In passing, it might be noted that this rule does not prevail in cases before the Industrial Accident Commission. In *Smith* vs. *Coleman*, 46 Cal. App. (2d) 507, the Court held that where an injured workman recovered damages for an industrial injury from his employer and insurance carrier before the Industrial Accident Commission, he could subsequently maintain an action for malpractice against a physician who had treated the injury.

LETTERS†

Concerning Medical Literature Sent to Military Camps in California—Letter of Appreciation:

STATION HOSPITAL

Camp Beale, California.
September 17, 1943.

California Medical Association,
450 Sutter Street,
San Francisco, California.

We received today by express the package of books and periodicals that the Association so generously sent us. We have a small library here at Camp Beale, but at the present time it is entirely inadequate for our needs. We certainly welcome any type of medical volumes and periodicals.

The Commanding Officer, Lt. Col. Charles H. Woodruff, wishes to personally thank the Association members for their thoughtfulness in helping to augment our medical library.

Sincerely yours,

(Signed) ALEXANDER G. BARTLETT,
Major, M. C., Chief of Medical Branch.

† CALIFORNIA AND WESTERN MEDICINE does no hold itself responsible for views expressed in articles or letters when signed by the author.

Concerning Obligations to Military Colleagues:

———, September 12.

Dear Doctor:

Your editorials in August CALIFORNIA AND WESTERN MEDICINE just reached my desk.

I feel that upon behalf of all my fellow officers we owe you a vote of thanks for your thoughtful consideration of our problems.

In my position, I hear the gripes and learn of difficulties of medical officers, and your ray of sunshine for the future is a big help to these officers.

These men in overseas units who will soon depart for combat areas are not worried about what will happen to them in the Army, but are most concerned about what is to come after they return home, if they ever do. Many of them have expressed to me their bewilderment and have wondered if it wouldn't be better for them to start anew in another location so that they wouldn't be ever faced with the other civilian's practice. To see the stay-at-homes have all the business and to be compelled to live on the crumbs is more than they care to face. Having gone through it once before, I personally know how it will be.

I am, at this writing, officer of a 1,000-bed, . . . overseas general hospital. Our departure is not too long distant. We have a group of the finest officers in the Army. Men from the leading medical schools all over the country. We have eight American Board diplomates in the various specialties. Many are best men of their communities, professors in universities and chiefs of staff of large hospitals. The average age of our senior officers is 46.

Please know how much we appreciate what those of you who are understanding are doing for those of us who are in the service.

Sincerely,

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Concerning Item on Scarcity of Women Physicians:

UNIVERSITY OF CALIFORNIA

San Francisco, September 17, 1943.

Editor,
California and Western Medicine,

Addressed.

Dear Editor:

In your August issue, on page 128, is an excerpt from the *Berkeley Gazette* regarding the scarcity of women doctors to enter military service now that they are eligible to do so. According to the March, 1943 issue of the *Medical Woman's Journal*, there are 2,146 women doctors in practice within the required age limits acceptable for military service. It is not stated how many of this number would not be acceptable for military service because their present work is essential or because they have children under 16 years of age.

The Sparkman Bill was passed in April, 1943. There has not been a considerable length of time for the clearance of papers commissioning women up to July 1, and transferring those in the services they were then eligible to. Under the present medical emergency, I think a quotation from Dr. R. B. Spencer, Director of the National Cancer Institute, appropriate: "Our national policy has been shortsightedness and ungenerous toward women who have had the urge to make their social contribution in the field of medicine." We have a limited number of women acceptable in medical schools and frequently discourage their progress. Up until the passage of the Sparkman Bill a woman doctor was unable to do equal work for equal rank and pay in the military service.

Very truly yours,

(Signed) ISABELLA H. PERRY, M. D.

TWENTY-FIVE YEARS AGO†

EXCERPTS FROM OUR STATE MEDICAL JOURNAL

Vol. XVI, No. 10, October, 1918

EXCERPTS FROM EDITORIAL NOTES

Fourth Liberty Loan.—The Fourth Liberty Loan campaign, which opens on September 28, 1918, and closes on October 19, provides a field for direct war work which no patriotic practitioner can shirk.

The size of the loan, certainly six billion dollars, probably eight billion, is huge. No sum approaching it in proportions has ever been gathered for any purpose by any nation, nor at one time, by any group of nations. Until the Great War made the daily expenditure of hundreds of millions of dollars common, the mention of such a loan would have seemed the wildest fancy. . . .

Fifty Thousand Medical Officers.—With an army of three million men in the field in September, 1918, or in training and as contemplated, an expansion of this force to five million men, the Surgeon-General must have in the Medical Reserve Corps at least fifty thousand doctors. The Medical Reserve Corps must keep pace in growth with the army expansion and it behooves every doctor in the United States between the ages of 21 and 55, who is physically, morally and professionally fit, at the earliest possible moment, to arrange his personal affairs so as to offer his services to his country in the capacity of a medical officer. The United States is in the war to win and this can only be accomplished by a large and well-trained body of troops adequately cared for by a sufficient number of medical officers. The importance of the doctor's service and its relation to the successful outcome of the war cannot be overestimated. . . .

Volunteer Medical Service Corps.—To date [October, 1918] about 40,000 of the 144,116 doctors in the United States—not including the more than 5,000 women doctors—either are in Government service or have volunteered their services. Up to July 12 the Surgeon-General had recommended to the Adjutant-General 26,733 doctors for commission in the Medical Reserve Corps. About 9,000 others who applied were rejected. With the 1,194 in the Medical Corps of the National Guard and 1,600 in the Navy, the total—38,527—constitutes 26.73 per cent of the civilian doctors. Deducting those who declined their commissions or who have been discharged because of subsequent physical disability or other cause, the number actually commissioned in the Medical Reserve Corps stands (August 23) at 23,531, with several hundred recommended whose commissions are pending. Of the 23,531 there are 22,232 now on active duty. . . .

Important Change in United States Employment Conditions.—The supplying of war industries with common labor will be immediately centralized in the United States Employment Service of the Department of Labor, and all independent recruiting of common labor by manufacturers having a pay roll of more than one hundred men will be diverted to the United States Employment Service. This is in accordance with the decision of the War Labor Policies Board and approved by the President on June 17. (The War Labor Policies Board is composed of representatives of the War, Navy, and Agricultural Departments, the Shipping Board and the Emergency Fleet Corporation, the

(Continued in Front Advertising Section, on Page 18.)

† This column strives to mirror the work and aims of colleagues who bore the brunt of Association activities some twenty-five years ago. It is hoped that such presentation will be of interest to both old and new members.

BOARD OF MEDICAL EXAMINERS OF THE STATE OF CALIFORNIA†

By N. F. Scatena, M. D.
Secretary-Treasurer

Board Proceedings

The annual meeting of the Board of Medical Examiners will be held in Sacramento, California, October 18 to 21, 1943, at which time written examinations will be held for physicians and surgeons. Legal hearings are also scheduled for this meeting as well as hearings on petitions for restoration of certificates heretofore revoked, and on petitions for modification of terms of probation heretofore imposed.

An oral examination is scheduled to be held at the Board office in San Francisco on November 18, 1943, at 10 a. m.

News

"The State Board of Medical Examiners today announced those who successfully passed examinations for physicians, surgeons, chiropodists, and drugless practitioners, held in San Francisco in the last three months. The highest mark for physicians and surgeons—91 plus per cent—was made by Herbert N. Hultgren of San Francisco, a graduate of the Stanford School of Medicine. . . ." (San Francisco *Call-Bulletin*, August 28, 1943.)

"Urgent need for 600 women doctors who will be commissioned in the Navy in ranks from lieutenant commander to lieutenant (junior grade) was announced yesterday by the Navy's Bureau of Medicine and Surgery. They would enter the Medical Corps, not the Women's Reserve, and would serve in the United States, relieving men doctors for duty on war fronts." (Los Angeles *Times*, August 21, 1943.)

"Medical schools have speeded up their courses by condensing four years' work into three. Nearly 7,000 doctors a year are being graduated by the sixty-six approved schools." (Biggs *News*, August 27, 1943.)

Sulpha drugs may be prescribed by chiropodists in the treatment of the human foot, Attorney-General Robert W. Kenny ruled yesterday in an opinion to the Board of Medical Examiners." (Los Angeles *Examiner*, August 10, 1943.)

"More progress in science's fight to produce penicillin, the latest 'miracle drug,' was reported today by Dr. Charles E. Clifton, Stanford University bacteriologist. . . . Doctor Clifton, pondering how to produce the 'yellow magic' faster, thought he might be able to grow penicillin in a continuous flow somewhat similar to vinegar conversion. Laboratory experiments confirmed his ideas, and now the drug can be made continuously and at relatively great speed. . . ." (San Francisco *News*, September 10, 1943.)

"Attorney-General Robert W. Kenny today sought White House aid for the continuation of medical and nursing service to tenants of war-housing projects in California. Acting as the head of the California Housing and Planning Association, Kenny telegraphed President Roosevelt that a breakdown of the program is threatened through inability of the contracting Physicians' Service to continue under present financial arrangements. He asked the Presi-

(Continued in Back Advertising Section, on page 30.)

† The office addresses of the California State Board of Medical Examiners are printed in the roster on advertising page 6. News items are submitted by the Secretary of the Board.